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The Social Route: Peruvian Psychiatrists and the Politics of Mental Health  
Reform

Juan Alberto Claux

Doctor of Philosophy  
The University of Edinburgh  
2018



## Declaration Page

I declare that this thesis has been composed solely by myself and that it has not been submitted, in whole or in part, in any previous application for a degree. Except where stated otherwise by reference or acknowledgment, the work presented is entirely my own.

Juan Alberto Claux  
19 September 2018



## Abstract

This thesis is about the prospect of change in the Peruvian mental health services system as seen through the lens of public psychiatry. It is based on the depiction of the work of psychiatrists in two of Lima's mental hospitals -Hospital Valdizán and Instituto Noguchi- and the projects of mental health services reform that I found in both of these institutions and an advocacy group sponsored by the Pan American Health Organisation. Ethnographic fieldwork was conducted from April 2012 to July 2013.

I portray the current paradigm of care that dominates the public psychiatric sphere by describing the practice of specialists in outpatient consultations and hospitalisation wards. What I call the empirical model of psychiatry is an objectivistic, pharmaceuticalized, and top-down practice that finds its most augmented version in the wards. It loses sight of such therapeutic mandates as cultivating rapport, giving voice, and providing social support, elements that can be encountered in alternative paradigms of care that hold a marginal position in today's mental health system, such as the community mental health model that was developed in the 1980s at Instituto Noguchi and has progressively faded into near oblivion.

The multiple inadequacies of treatment reviewed in this thesis, which are fuelled by a historical relegation of mental health policy in the country, speak of a psychiatry that is far from effectively improving the lives of service users. This was the greatest blind spot revealed by the mental health reform agenda; the need to improve psychiatry as a therapeutic practice was largely absent from reform discourse. Another important issue encountered was the failure of initiatives focused on training primary healthcare professionals in detecting and treating mental health problems (task-sharing). I argue that sustainable task-sharing strategies, added to comprehensive and locally-sensitive models of mental health services, should be explored.

Finally, there is a paradox to be solved in relation to mental health governance in Peru. Psychiatry has hegemony; it owns the national institute of mental health and presides over the national mental health direction at the Ministry of Health. However, as a profession it has remained alienated from public health matters, absorbed in the daily practice of public hospitals and private practices. Mental health governance, then, needs to be balanced with the contribution of other professions and this is where the social route of the mental health system gains significance: anthropology has great

potential to help develop a richer understanding of people's mental health and craft effective services in socially unequal and multicultural societies.

## Lay Summary

This thesis is about the prospect of change in the Peruvian mental health services system as seen through the lens of public psychiatry. It is based on the depiction of the work of psychiatrists in two of Lima's mental hospitals -Hospital Valdizán and Instituto Noguchi- and the projects of mental health services reform that I found in both of these institutions and an advocacy group sponsored by the Pan American Health Organisation. Ethnographic fieldwork was conducted from April 2012 to July 2013.

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## Contents

Figures .....	viii
1. Introduction.....	1
2. Mental health Reform: Policy and Governance.....	39
3. Community Mental Health at Hospital Valdizán.....	61
4. Community Mental Health at Instituto Noguchi.....	89
5. The Outpatient Area.....	119
6. The Hospitalisation Wards.....	143
7. Conclusion.....	175
Bibliography.....	201

## Figures

1. The location of Lima's three psychiatric hospitals.....	27
2. Income per capita map of Lima (INEI, 2016, p. 14).....	28
3. Me pretending to write something with a psychology intern in one of the community centre's consultation offices.....	65
4. The dartboard and Humberto Rotondo.....	68
5. ASUMEN's poster.....	190

## Introduction

I met Carlos Rodríguez at Hospital Valdizán's emergency area in 2007. I was doing fieldwork for my undergraduate thesis and went there looking to meet a person with a schizophrenia diagnosis and their family members. Carlos (68 years old) and his wife, Rosa (37 years old), had taken their son, Jorge (15 years old), to the hospital because his psychosis had gotten out of hand. I asked them if I could visit their home and talk about Jorge's illness and Carlos accepted enthusiastically. He was visibly concerned and told me that I could teach them about this ailment. In addition to the son, his wife had a twenty-three-years old course of schizophrenic illness.

Some days later, I went to their house in San Juan de Lurigancho, a million-people district inhabited by middle class and poor families alike. The Rodríguez family lived in a single-room house made of straw mats and plywood in one of the district's pockets of poverty. The bus left me some blocks away from their neighbourhood and I walked through a dirt path into an open space with a small football pitch in the middle, where some boys were playing a match. One of them saw me from afar and, because I'm white, called me a name after a popular sitcom character of the time. I laughed while I searched for the nearest bodega where I could ask the owner how to get to the Rodríguez address. Their home was to one side of a set of concrete steps that took you over one of the many arid hills of the area.

The couple had three daughters that did not live with them. The eldest lived in a shelter for rape victims, the second eldest in a shelter for abandoned kids, and the last one with Rosa's mum, also in San Juan de Lurigancho. According to Carlos, they did not live with them because the house was too small and it would not be good for them to share it with two persons with schizophrenia. The family did not make much money; Carlos sold second-hand clothing at a local marketplace and Rosa had never been able to keep a job for too long. At that time, she had landed jobs in a restaurant and in the neighbourhood's comedor popular (soup kitchen), which allowed her to take food to the

house.

Jorge had abandoned his studies after finishing primary school because he became addicted to terokal, an industrial adhesive used as an inhalant drug. At that time he was diagnosed with schizophrenia at Instituto Noguchi and went into a drug rehabilitation centre in San Juan. He was discharged a year later because he became infected with tuberculosis. Back at home, he had a psychotic break and started acting aggressively and erratically, leaving the house whenever he wanted. His parents took him to Noguchi again, but—due to a change in hospital catchment areas—he was transferred to Hospital Valdizán, where I met him in the emergency area. Minors are not hospitalised in these establishments, so he was prescribed antipsychotic medicine and was told to return in three weeks for an outpatient consultation. He started taking the meds for the first time and did not like their side effects—while I was in their house, he kept asking his mom if he could stop taking them. He finally did and was placed in the drug rehabilitation centre because his parents were afraid that he would start consuming terokal again. He did not make it to his hospital appointment. Additionally, Carlos and Rosa wanted to take Jorge to a curandero but they did not have the money.

Rosa, for her part, was diagnosed at Noguchi when she was a teenager and, initially, her parents paid for treatment. They stopped helping her, however, when she married Carlos and, as a consequence, she has gone on and off treatment intermittently throughout the years, suffering periodical psychotic relapses. She was stable at the time of my visit, although she reported having insomnia due to having discontinued her psychiatric pills a month before. Carlos told me that Rosa has violently attacked him a couple of times after stopping her meds: he fractured his arm once when she pushed him from a second floor and, on another occasion, she smashed his foot with a construction iron rod.

Carlos expressed a sense of helplessness about his situation:

I would not mind living like this if my family was healthy, that would be alright. But my problem is double: poverty and that incurable illness. There should be people in charge of this, of looking out for those who need help, see our cases. I have asked for help, they just ignore me. These cases should be seen by the government. Not just the government, there should be institutions or someone who can report this case.

This story illustrates many of the issues that motivated me to undertake a study about the practice of public hospital psychiatrists. It shows how poverty generates multiple problems that mutually reinforce themselves, and further exacerbate poverty, making it impossible for some families to follow psychiatric treatment. It also shows the problematic side effects of psychopharmaceuticals and their withdrawal, as well as alternative healing options that are considered by some. Finally, it displays psychiatry's disconnect with this reality, making it appear it is highly ineffective in achieving treatment adherence and patient outcome improvement. Thus, this situation prompted me to take a look within these hospitals and see the extent to which psychiatrists sought to improve their practice and the system of public mental health services.

Another aspect that intrigued me prior to this study was the exaltation of Peruvian psychiatric figures of the twentieth century. The hospitals of my research are named after the oldest of these references, Hermilio Valdizán and Honorio Delgado.<sup>1</sup> Valdizán was a pioneer: he created the first psychiatric outpatient service in the country, taught the first psychiatric course in 1916 (Mariátegui, 1980, pp. 2-5), and ended up being director of the psychiatric hospital Victor Larco Herrera in 1921 (Mariátegui, 1980, p. 16). He died at a young age in 1929 (Villa-García and Neyra, 2000, p. 41). He also created the first psychiatric journal in Peru with Honorio Delgado, who was his student and collaborator, in 1918 (Arias, 2015, p. 290). Starting in 1920 (Arias, 2015, p. 296), Delgado developed a prolific research and clinical career at Hospital Larco Herrera for over 40 years (Galli, 2000, p. 131).

Then came Carlos Alberto Seguí, who created a psychiatric service in a general hospital called Hospital Obrero in 1945, and also developed a fruitful clinical career over the following decades (Huarcaya-Victoria, 2016, p. 405). Finally, Humberto Rotondo and Javier Mariátegui were the first leaders of Hospital Valdizán and Instituto Noguchi in the early 1960s (Mariátegui, 1985, p. 259) and early 1980s (Mariátegui, 1988, p. 241) respectively. Their names and images are commemorated in hospital areas, busts, ceremonies and conferences, and they were highly praised when I talked about the history of psychiatry with informants. Once, when I was in one of Hospital Valdizán's

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<sup>1</sup> The hospital which I refer to as Instituto Noguchi or Noguchi throughout my thesis is called Instituto Nacional de Salud Mental Honorio Delgado-Hideyo Noguchi. The name of a famous Japanese microbiologist who had studied neuropsychiatric disorders was included because the place was initially funded by the Japanese government.

hospitalisation wards, a resident asked an attending psychiatrist if Rotondo's notes could be seen in old medical records of the hospital. "What was his handwriting like?" she asked. "Very legible." "And hasn't someone put these records in a museum?" "No, nobody has done that."

However, some of the most reflective people I met say that these maestros, as they are frequently referred as<sup>2</sup>, are a thing of the past. Alberto Perales, a Noguchi founding member back in the early 1980s, told me: "Those leaders do not exist anymore. We have prominent psychiatrists, but we cannot talk about schools of thought anymore." Lizardo Cruzado, a Noguchi psychiatrist who has written a lot about how past times were better in his personal blog (<http://desdeelmanicomio.blogspot.pe/>), thinks similarly: "A school of thought is made possible by a maestro. Not a location, a group of settings or patients, but a maestro. Who are the maestros of Peruvian psychiatry today? We would have to see. Unfortunately, they do not seem to abound."

Rotondo and Mariátegui were both influenced by Honorio Delgado, whose main contributions were in the fields of biological and pharmacological treatment and phenomenologically-oriented clinical psychiatry. Rotondo supplemented Delgado's clinical training with psychological perspectives that he became exposed to during his residency at the Henry Phipps Clinic at Johns Hopkins Hospital, especially the interpersonal psychoanalysis of Harry Stack Sullivan. Mariátegui, for his part, continued developing the bio-pharmacological perspective of Delgado and was considered his disciple. He was also quite close to Rotondo, who taught him psychology courses in medical school and helped him with his undergraduate thesis about the psychopathology of LSD intoxication (Mariátegui, 1985, pp. 254-256)

A first aspect that is admired about these psychiatrists is their dexterity in the clinical observation of mental illness. Honorio Delgado is praised for the dense phenomenological descriptions of psychopathology he wrote about in books that have been studied by countless Peruvian practitioners. Mariátegui (1985, p. 252) regarded Rotondo as a "fine psychopathologist and semiologist" who formulated rich descriptions of the patient's family and social contexts. In contrast, in a 1997 conference at Instituto Noguchi, Mariátegui expressed concern about the declining quality of clinical psychiatry, stating that diagnostic practices had forgone the comprehensive study of the

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<sup>2</sup> In the case of Rotondo, for instance, maestro was used as a common prefix to his surname.

patient, producing a banalisation of psychopathology. Homogenisation does not necessarily lead to progress, he pointed out (Vargas, 1998, p. 56).

I have taken the title of this thesis from an article by Mariátegui called *Ruta Social de la Psiquiatría Peruana* (1972). The social route of Peruvian psychiatry was delineated by him and others in articles and studies. Peruvian psychiatrist Alarcón, who was a student of Mariátegui, stressed in 1976 the importance of the “socio-ambiental” tendency of psychiatry and referred to the apathy of psychiatrists who stayed confined within the walls of the specialised hospital (1976, p. 115). Mariátegui also denounced that psychiatrists were out of touch with social reality and proposed they should take note of the country’s socioeconomic transformations. He argued that psychiatry should complement classical references with fieldwork and ground analysis, and that practitioners should notice migration had produced a new type of man inhabiting the city (Mariátegui, 1988, pp. 40-41).

Perales, who was Noguchi’s head of research during Mariátegui’s period as director of the hospital, drew attention to sociocultural variation in mental health. He prompted his colleagues to be aware that the sociocultural mosaic of the country can make the healthy behaviours of a region come into conflict with accepted norms in other regions (Perales, 1989, p. 107).

In the 1950s, Rotondo and Seguí developed separate research projects in what was called the field of social psychiatry, although this coincidence came without collaboration. Rotondo had been appointed as head epidemiologist of the mental health department in the Ministry of Health and, over a decade, he and his team studied different kinds of populations in Lima. Mariátegui (1985, pp. 257-258), who was part of the team, recalled they read classical sociological authors before entering the field, in what he recalls as a widening of the psychiatric horizon. They engaged in interdisciplinary work, teaming up with an anthropologist, a social psychologist, and social workers, and presented their work at a social sciences seminar. They made sense of mental health problems such as depression and anxiety by linking them to social contexts of scarcity and hopelessness (Rotondo, Caravedo and Mariátegui, 1963). The project was abandoned when Rotondo embarked on his Hospital Valdizán adventure in the early 1960s.

These psychiatrists had a prolific academic career beyond the domain of social psychiatry. They developed multiple research topics, published psychiatric manuals,



and created specialised journals. They were reflexive, in the sense that they critically explored different theoretical perspectives of psychiatry, and familiar with the social sciences and humanities. Moreover, they created an academic hospital life where knowledge-craving students could engage in rich intellectual exchange and nurturing. Trained in this environment, Mariátegui (1988, p. 43) highlighted the importance of empowering Peruvian psychiatry and its research production and avoiding a colonialist dependency towards the scientific tendencies of developed countries.

Mariátegui's preoccupation for establishing an original national psychiatric identity is documented in many of his books and articles about the present state and history of Peruvian psychiatry (Mariátegui, 1987; Mariátegui, 1999), and about the professional trajectory and contributions of multiple local figures (Mariátegui, 1985). Alarcón has extended this line of inquiry to the Latin American level (Alarcón, 1990; Alarcón, 2012). The older psychiatrists are presented as having been empowered to the extent of directly contributing to the international scientific consensus of psychiatry, like Honorio Delgado who was at the forefront of therapeutic developments (Mariátegui, 1997), or Humberto Rotondo who was a frequent WHO collaborator (Mariátegui, 1985).

Finally, these psychiatrists were committed to the development of public psychiatry. Mariátegui (1985, p. 261) reveals that Rotondo saw private practice as an obstacle and wanted to abandon it. Most had some sort of participation in public policy, taking part in advisory groups that mostly advocated the creation of a mental health department within the Ministry of Health and created national health plans, but their efforts usually fell on deaf ears. Their most significant contributions to the advancement of public psychiatry came through the hospitals. Instituto Noguchi established a model of mental health services reform in their catchment area and had the mandate to provide public policy consultancy to the Ministry of Health, while Rotondo's main contribution is said to have been training more than 70 psychiatrists at Hospital Valdizán. Rotondo also sought to spread mental health competence to other professions and areas of the country by teaching courses to medical students, social workers, and health professionals from other regions (Mariátegui, 1985, pp. 260-261).

In an interview that took place in his private office, Peruvian psychiatry historian Ricardo Bustamante stated that money was an important explanatory factor for the declining academic relevance of Peruvian psychiatry in the twentieth century. According to him, Peruvian psychiatry had a brilliant decade between 1920 and 1930 because an

agricultural entrepreneur called Víctor Larco Herrera funded the first mental hospital, which was subsequently named after him. With his hefty total donation (equivalent to more than a million dollars), the hospital became equipped with infrastructure, state-of-the-art services, specialised professionals, anatomy and clinical labs, a print shop, and a library that Larco Herrera imported from Europe. With the drive of Hermilio Valdizán and Honorio Delgado, among others, the hospital became a vibrant place in which to practice, learn, and undertake research. When Larco Herrera stopped funding the institution, however, its budget plummeted and it was unable to maintain the quality of its services. Nevertheless, the academic development did not immediately go away with the funds; there was a next generation of prominent psychiatric figures, like Rotondo and Mariátegui, who had been trained in this privileged environment. According to Bustamante, the Peruvian state never provided the kind of funding needed to maintain this sort of development, and the “grandes maestros” eventually started to disappear.

The influence of Larco Herrera’s investment and the lack of government interest in mental health have had an undeniable impact on the development of Peruvian psychiatry in the twentieth century. The public sector has remained relatively neglected and mental health reform has not been given enough support. But I think that the creation of a large national institute of mental health like Noguchi did generate academic development to some extent. Unlike Hospital Valdizán, Instituto Noguchi has groups of people that have developed consistent research and clinical agendas throughout its existence. However, psychiatry’s domains of interest have become narrower. It is harder to find practitioners debating the merits of phenomenological theories of psychiatry or developing a social psychiatric agenda, and this is perhaps not only a product of lack of funding, but also of psychiatry’s tendencies as a discipline since the 1980s and 1990s, which led to the dissemination of a paradigm of practice that is less theoretically reflexive and more focused on psychopharmacology.

This thesis is about the prospect of change in the Peruvian mental health services system as seen through the lens of public psychiatry. It is based on the depiction of the work of psychiatrists in two of Lima’s mental hospitals—Hospital Valdizán and Instituto Noguchi—and the projects of mental health services reform I found in both of these institutions and an advocacy group sponsored by the Pan American Health Organization (PAHO). In chapter two, I trace the history of mental health governance in the country since the 1950s, offering an analysis of why reform has remained elusive

throughout this period. I also describe the work of a PAHO-sponsored civil society group that sought to develop a wide-ranging strategy of mental health reform advocacy and how hospital psychiatrists had distanced themselves from this endeavour.

Chapters three and four are based on the fieldwork I did in the community mental health departments of both hospitals, where I found that mental health services reform projects had been recently implemented and were marginalising the community psychiatry perspective that had formerly dominated these spaces. In addition to the usual suspects of psychiatry's involvement in public health matters—neglecting the social determinants of mental health, lacking cultural competence, narrowing down services to psychopharmaceutical prescription—I found these programmes encounter multiple obstacles in the implementation of task-sharing that are related to the status quo of general health services and personnel. At Noguchi, I found a rich community psychiatry tradition developed in the 1980s that had progressively faded into near oblivion. This model was quite different to hospital psychiatry; it offered a comprehensive set of services, it was intersectoral, and it promoted therapeutic values such as cultivating rapport and taking the patient's view into account.

In chapters five and six I portray the current paradigm of care that dominates the public psychiatric sphere by describing the practice of specialists in outpatient consultations and hospitalisation wards at Hospital Valdezán. What I call an empirical model of psychiatric care is characterised by objectivistic and superficial clinical work, a therapy repertoire that is narrowed down to psychopharmaceuticals, and a top-down approach that silences the service user's own view of mental health and seeks adherence through methods of persuasion or coercion. This perspective finds its most augmented version in the wards, where I also found a rigid and paternalistic disciplinary system of patient management, indiscriminately coercive measures, and an inadequate distribution of space that affects patients' mental and physical integrity. This portrait is in part determined by the historical relegation of mental health policy in the country, which has maintained the mental health system with scarce resources and centralised in a small number of hospitals. Practitioners are usually aware that they could be offering a better service, but they meekly accept this reality and continue to undertake a double standard of care in their public and private practices.

In the conclusion, I develop a critique of the mental health reform agenda and suggest a new social route for Peruvian psychiatry. The multiple inadequacies of

treatment reviewed in this thesis speak of a psychiatry that is far from effectively improving the lives of service users. This was the first blind spot revealed by the mental health reform agenda: the need to improve psychiatry as a therapeutic practice was largely absent from reform discourse. The other one was related to reform strategy, which has historically been focused on the integration of mental health functions in general health services (task-sharing). This approach has proved tough to implement and I suggest that attention should be veered towards the decentralisation of professional training in order to provide the specialised human resources that are needed to build a comprehensive and sustainable national system of mental health services.

Finally, a paradox must be solved in relation to mental health governance. Psychiatry has hegemony; it owns the national institute of mental health and presides over the national mental health direction at the Ministry of Health. However, as a profession, it has remained alienated from public health matters, absorbed in the daily practice of public hospitals and private practices. Mental health governance, then, needs to be balanced with the contribution of other professions and this is where a renovated social route of the mental health system gains significance: anthropology has great potential to help develop a richer understanding of people's mental health and craft effective services in socially unequal and multicultural societies.

## An Ethnography of Public Psychiatry

This work can be characterised as hospital ethnography. However, I did not want to depict psychiatric practice in a synchronic manner or as if it existed in a void. Aiming for a dynamic portrayal of psychiatry was what got me interested in the historical figures of the twentieth century, in the history of mental health policy, and in choosing the most progressive and reformist fieldwork sites. My interest lies in understanding change—or lack thereof—in psychiatry, both past and present. Are today's practitioners different than the ones who came before them? Why has the system of mental health services remained so limited for so long? What are the possibilities of future change in these two domains?

Furthermore, my wish to present a contextualised psychiatric practice led me to including other sites and aspects of professional practice in my fieldwork. Aside from

my main ethnographic site at Hospital Valdizán, I went to Instituto Noguchi, the meetings of an advocacy group for mental health reform, the meetings of a service user organisation, and also had a wealth of interview material with schizophrenia users and family members from Hospital Valdizán that I had compiled some years before. Within the hospital, I wanted to make a holistic assessment of psychiatrists and thus also paid attention to aspects such as training, research, and internal politics.

This intent has been voiced before by authors who have critiqued hospital ethnographies of the past. These early studies have been accused of having a “functionalist approach” which overemphasises the stability of hospital social organisation (Strauss et al., 1981, p. 13) and of conceiving these institutions as islands, forgetting that they are situated in specific professional and political macro structures (Katz, 1992, p. 356). Street and Coleman (2012) argue against viewing hospitals as isolated or socially integrated spaces and suggest that we move beyond this dichotomy by understanding these institutions as complex spaces that are layered, contested, contingent, and simultaneously bounded and permeable.

Furthermore, as psychiatry expands its area of influence and stretches over new territories, its “fundamental assumptions are disrupted and unsettled” by “inter-institutional tensions and analytical upheaval (Béhague, 2008, pp. 143-144).” Tensions and upheaval generate processes of change, in which emergent ideologies and psychiatric configurations start to appear. There are hospital studies, some of them multi-sited, which have taken these processes into account, achieving a more dynamic portrayal of the psychiatric institution.

Strauss et al. (1981), the first of the multi-sited ethnographies that I will mention, observed three different types of psychiatry—somatic, psychotherapeutic, and sociotherapeutic—in two different settings, a public and a private hospital, in Chicago’s psychiatric scene. They concluded that there is a whole world beyond the formal rules and conventions of institutions, where division of labour and relations among cliques are sorted out through processes of bargaining and negotiation. As a result of these processes, new treatment practices and ideologies can develop, or old ones can be transformed.

Katz’s piece (1992) on a public hospital in Maryland, although not multi-sited, is another example of how the larger mental health system is taken into account as a key analytical component and, also, a depiction of an instance of change in psychiatry. In

1976, a university-trained psychiatrist became an authority in Maryland's mental health system and enabled the entry of more than 200 young university psychiatrists to the public state mental hospitals. This generated a "clash of cultures" between two types of psychiatrists that had until then been working in separate spheres. The medical school crowd was elitist and had traditionally catered to the higher socioeconomic classes. University training was progressive; it promoted the study of mental illness and change in psychiatric institutions. On the other hand, psychiatrists in public hospitals were immigrants who had landed low-status jobs in the American medical environment. Katz describes them as having low morale, not complying with work obligations, and deeply immersed in the routine. The state mental hospital that she observed was a context that precluded innovation and left no space for change. When a university-trained psychiatrist arrived to become the new hospital director, state practitioners offered considerable resistance. However, after two years, resistance waned and hospital operations improved considerably.

A third example is Luhrmann's ambitious ethnography of American psychiatry (2001). Her study was quite multi-sited: residency programmes, diverse kinds of private and public hospitals, a scientific research unit, psychiatric conferences, and her own participation in psychotherapy as a patient. Through the examination of different aspects of psychiatry—perception of mental illness, the doctor-patient relationship, the hospitalisation process—, Luhrmann portrays two historical processes of change related to psychiatry's therapeutic landscape and health policy. These were the overthrow of psychoanalysis by biomedical psychiatry as the hegemonic therapeutic paradigm and the rise of managed care as the ruling scheme of healthcare governance. With the latter, a biomedical model of psychiatric service, short-term hospitalisation, was prioritised over psychoanalytic therapy because it was thought to be more cost-effective.

## Hospital Psychiatry

In the 1980s and 1990s, a handful of medical anthropologists analysed what some of them called "psychiatry's culture", a set of meanings, modes of thought and practices that were set in motion by American psychiatrists, known as the "Neo-Kraepelinians",

when they attained the paradigm change from psychoanalysis to biomedical psychiatry (Good, 1992; Kleinman, 1988; Littlewood, 2002). In their quest to gain legitimacy as a scientific discipline, the Neo-Kraepelinians introduced a new taxonomic system of discrete diagnostic categories, in which each disorder could be reliably identified by different practitioners. They only had to check that the patient showed the set of criteria listed on the diagnostic manual (DSM-III) for each disorder. This diagnostic method was based on the description of symptoms, rather than the psychoanalytic *modus operandi* of defining etiology. This model was said to reproduce the biomedical concept of pathology, whereby disorders are tied to specific symptoms, physiological cause, disease course, and pharmacological treatment.

In order to maintain the coherence of the new diagnostic system, a kind of form/content distinction was established, whereby each category of disorder was assigned a core set of symptoms that were the universal pathogenic determinants, leaving personal and cultural variations as pathoplastic variations, and which therefore lacked the worth of the previous system (Littlewood, 2002, p. 5; Kleinman, 1988, p. 24). The core pathological structure was the real disorder, usually camouflaged by superficial particularities. Littlewood (2002, p. 7) notes that, in reality, clear-cut pictures of “distinctive” symptoms are hard to find, and the way in which sameness and difference are defined has to do less with the natural order of things than with arbitrary distinctions meant to fulfil psychiatry’s purposes.

These authors pointed out that a number of relevant elements were being sidelined by the biomedical model of psychiatry: subjective meaning and experience, historical context, the therapeutic relationship, issues of power, and the structural determination of social inequality were all being obscured by the medicalised view of mental distress. Many of these ideas have been re-evoked and refined by the anthropological inquiry of psychiatry of the last decades. Jenkins (2004) and van Dongen (2004), for example, provide a critical appraisal of how psychiatry engages with schizophrenia and lay out some suggestions as to how this process should be improved. According to them, psychiatry pathologises psychosis by labelling patients as “out of touch with reality” and establishing a crude distinction between them and normal people. In the therapeutic encounter, psychiatrists test patients for abnormality by looking for a series of standardised markers such as delusions and disordered speech. The person’s subjective experience of psychosis is deemed irrelevant and psychological therapies

are frequently considered inappropriate.

Jenkins (2004, p. 31) states that psychosis is more normal than it is generally considered, making the point that it is best regarded as ordinary, but intensified, human experience. Both Jenkins and van Dongen bring up the “self-processes” through which psychotic people cope and struggle to regain control over their experience. Far from being passive and helpless victims, their speech and actions show features of agency and purposiveness. Psychotic discourse is not simply the meaningless babble of troubled minds; it is, in fact, highly symbolic and rife with figurative language that can be interpreted as representation of the subject’s illness experience. And this discourse does not transcend the boundaries of culture, as common belief would have it; rather, people with psychosis “work with culture”—they make use of culturally available symbolic patterns in a bricolage-type self-process (van Dongen, 2004, p. 20).

In addition to how psychiatry views and deals with mental illnesses, I will discuss anthropological contributions that resonate with my analysis of clinical practice at Hospital Valdizán. I have tried to document the “taken-for-granted ideas and practices” (Barrett, 1996, p. 10), and their tacit assumptions, found in everyday clinical routines and interactions. My observations will show, however, that psychiatrists do not always remain oblivious or unreflective, and how important it is to take into account the manner in which the clinical setting impinges upon their praxis. As a discipline that is applied in real hospitals within specific systems of services that have contours and limitations, public psychiatry is traversed by pragmatic motives that sometimes force practitioners to put their doubts and discomforts on hold and carry on with the show.

Csordas et al. (2010) show the effect that structured clinical interviews have on patient narratives. By comparing semi-structured ethnographic interviews and the Structured Clinical Interview for DSM, they found that the answers of some people for the same topic varied considerably in both interviews. This shows the extent to which interview methodologies have narrative constraints that determine the way in which patients talk about themselves and the interpretations psychiatrists make. Furthermore, authors have depicted how professionals’ neglect of patient and family perspectives give way to tensions between different explanatory models of mental illness and general cultural ideologies, with the risk of rendering communication ineffective and engendering resistance towards psychiatry’s script (Gaines, 1982; Wilce, 2004; Tran, 2016; Marrow, 2013; Orr, 2013; Koss-Chioino and Canive, 1993). Clinical interpretive



methodologies such as the cultural formulation interview and alternative ways to elicit patient explanatory models and develop culturally pertinent treatment practices that enhance mental health outcomes have been analysed and advanced in response to these problems (Adeponle, Groleau, and Kirmayer, 2015; Groen, 2009; Nastasi et al., 2015; Hinton, Hinton, Eng, and Choung, 2012; Kohrt and Hruschka, 2010; Saglio-Yatzimirsky and Sébastia, 2015; Velpy, 2008).

A central preoccupation in psychiatric clinical practice is the achievement of treatment adherence. If patients are not willing to adhere, then they must be persuaded. Rhodes (1984) provides an analysis of the communicative devices which underlie this negotiation process between provider and client. Most notably, metaphoric language is employed in the intent to establish successful communication strategies, such as “making one’s own inner experience, both physical and mental, visible and comprehensible to others” and “to use the experience-near concepts of the person to whom you are trying to communicate” (Rhodes, 1984, p. 67). Persuasion is sought for by these means, regularly by psychiatrists and sometimes by patients. Similarly, Ecks (2014) describes how some psychiatrists from Calcutta use a food metaphor, consonant with local culture and forms of care in order to persuade patients to take psychotropic long-term treatment.

The process of adherence, or “compliance”, has been analysed by Floersch and Longhofer (2010), who define two broad predispositions towards medication. The first, instrumental desire, is when patients expect pills to be effective in making symptoms disappear. If they do not work, another course of treatment may be taken; if they work, it is no longer necessary to keep taking them. Concordant desire, on the other hand, happens in the context of chronic mental illness, when treatment needs to be maintained over a longer period of time. Here, medication may acquire a new meaning, becoming central to the patient’s illness identity. This latter configuration of desire, the authors argue, is critical for long-term compliance. But it might be difficult to achieve, as Jenkins and Kozelka (2017, p. 155) have suggested, since discontinuation rates seem to be very high in low-income and high-income countries alike. They assert that recovery of social functioning, and not the reduction of targeted symptoms, is at the top of the value hierarchy of patients everywhere and, thus, psychopharmaceuticals do not completely satiate their needs and may even work against them by inflicting considerable side effects and making it hard for them to fulfil expected social roles.

Therefore, it is important to take the patient's perspective on treatment needs into account. How they interpret doctor's orders, their own health goals, and how they handle medications, for instance. According to Kaljee and Beardsley (1992), compliance is a medically-centred concept that carries unexamined notions about the power that practitioners have over patients in defining and treating mental illness. Noncompliant practices such as not taking the medications or modifying dosages unilaterally, the authors note, may signify attempts to reclaim agency over one of the few life domains that patients can still control.

Another topic that remains relevant is the coercive and iatrogenic component of psychiatric treatment. Goffman (1961) initially brought this aspect up in his portrayal of an American mid-twentieth century asylum. He depicted how the total institution subjects patients to a process of identity transformation, where they are stripped of all that is associated to their former identity and personal freedom in order to conform to a new inmate identity regulated by the institution. At the same time, he shows the "underlife" of the institution, comprised by rebellious acts from patients that disobey formal hospital rules in hopes of asserting a sense of personal agency in the midst of institutional coercion. Decades later, Hershel (1992) analysed rule rigidity in different psychiatric settings and concluded that flexible clinical settings, where empathy and patient expression is encouraged, leave patients better prepared for the outside world.

Others have written about the tensions produced between practices of constraint and the therapeutic mandate of the psychiatrist. Brodwin (2014), for instance, highlights the uneasiness that frontline clinicians feel towards involuntary commitment because it challenges their angle on how a caring relationship should look like. Furthermore, Velprey and Eyraud (2014) and Hejtmanek (2014) illustrate how psychiatrists in units for patients with dangerous behaviour and the administrators of an institution for mentally ill youth, respectively, refuse to identify the coercive practices of confinement and restraint as therapeutic.

## Psychiatry in the Community

Deinstitutionalisation generated the appearance of a new set of aftercare services in developed countries. Estroff (1985) was one of the first anthropologists to write about

this world, most commonly referred to as “the community”. Her portrayal was bleak; a warning of the perils of deinstitutionalisation and a blueprint of key topics that the anthropology of psychiatry was going to develop in the following decades. Patients who had been discharged from hospitals in the US were suffering exclusion and were not recovering from chronicity.

Lucas (2001) and Pols (2016) question the use of the community concept in mental health policy as an adequate descriptor of the social realities of patients after institutionalisation. According to them, it seems to be a ubiquitous, taken-for-granted, and equivocal category that was erected in opposition to psychiatric asylums. The implicit understandings of neighbourhoods as close-knit communities and families as supportive and loving environments are rendered problematic by the actual forms in which patients make use of social spaces and establish relationships. Lucas points out that “the community” in Adelaide’s mental health services reform really just boils down to the individual home as a site of dwelling and treatment. The problem, as he evokes, is that subjects usually end up profoundly isolated, indulging in paranoia and defensively withdrawing themselves from any social contact.<sup>3</sup> Pols, on the other hand, illustrates that, when discharged from psychiatric institutions, Dutch patients socialise among them in empowering ways. They do not, however, engage in significant contact with “normal” citizens, and their association is better described as a network than a community, given that it is not tied to any specific locality.

In addition to the figure of withdrawal, people with mental illness suffer abandonment from their families and society as a whole. In the streets or within the household, subjects can be excluded to a great extent from social relationships, and authors such as Marrow and Luhrmann (2012) or Biehl (2005) have analysed the social, cultural, and political economic forces that conduce to this situation.

Anthropologists have also illustrated how well-intentioned and progressive recovery programmes can set forward unrealistic goals that staff and patients are not able to attain. Be it Greek patients who are not able to effectively embody the ideals of autonomy and responsibility being pushed by psychiatric services reform (Davis, 2012), mentally ill homeless people caught in the incongruity between a programme which

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<sup>3</sup> Corin (2007) has further elaborated on the topic of social withdrawal, showing that in addition to its defensive functions, some people use isolation positively as a protected space where they can improve at their own pace.

emphasises patient choice and structural conditions that greatly limit their freedom to choose (Lovell and Cohn, 1998), or patients in a peer-led recovery programme who find themselves facing the challenging path towards recovery alone, and without the necessary resources and assistance (Myers, 2015b), services are often guided by ideologies that set the bar too high for many patients that are not in the appropriate state of wellbeing to easily fulfil the expectations. Brodwin (2011) elaborates on the same kind of problem from the perspective of community outreach service providers, who develop a sense of futility and demoralisation when patient therapeutic goals set by the recovery paradigm run up against numerous obstacles.

Von Peter (2010, p. 25) sums up this issue well and proposes an alternative personalised model of recovery:

Suffering will remain, especially when solutions are formulated too promptly. Personal time is individually configured and cannot be accelerated by standardized techniques, just as we cannot force change at certain points in time. Perhaps it would be better to approach time in therapeutic circumstances as a verb, rather than as a noun, seeing that individual temporal configurations are actions and ways of being. Most importantly, such an approach would facilitate to wait for changes within persons and situations, without a teleology that weighs down expectations. It is a waiting that remains still and noninvasive when the situation is disadvantageous for change. Such waiting gains time, instead of losing it (Oury, 2000, p. 4). It requires a lot of patience—and a medical system that allows for patience and for immobility as part of therapeutic activity.

Hopper (2007) laid out a comprehensive blueprint of the territories that recovery efforts should cover in hoping for better results. In addition to helping at the individual level, bolstering coping skills and generating “enhanced agency”, programmes should seek to expand the scenario of restricted opportunity that dominates most lives of the mentally ill by transforming social environments.<sup>4</sup> Social interventions can be divided in two domains, material and sociocultural. The first consists in granting support that redresses socioeconomic inequities and the latter is about changing public perception and attitude towards mental illness in order to create the possibility for recovering subjects to acquire socially valued roles. Real self-determination and aspirations for a successful life have to be approached by expanding social opportunities for the

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<sup>4</sup> Other authors that point to the need for engaging in social intervention are Lovell and Cohn (1998) and Myers (2015b).

chronically mentally ill.

A couple of anthropologists have written about successful programmes that have socially included the mentally ill to a great extent. Roosens and Van de Walle (2007) analyses the present state of the legendary Geel programme that has placed thousands of patients in host families since at least the thirteenth century; and Nakamura (2013) examines the therapeutic logics of Bethel House, a community of mentally ill people in a small Japanese village that has sought social reintegration through the development of work programmes and the generation of close ties with the locals. These experiences testify to the importance of the social bond and its potential for enabling the realisation of meaningful lives.

Finally, an important global tendency that has come into being with deinstitutionalisation is the pharmaceuticalisation of psychiatry and the public. In countries like Peru, this process has been limited because psychiatry has not been democratised, but mental health services reform will surely make pills more available. In countries where psychiatry is more developed, anthropologists have found practices of overprescription, overuse, and polypharmacy. Although the pharmaceutical industry has considerable responsibility in this matter, authors have weighed in multiple factors that can generate geographies of high prescribing (Oldani, 2014; Nunley, 1996). Moreover, psychopharmaceuticals are not only overprescribed by psychiatrists, but also by primary care doctors and informal practitioners (Ecks and Basu, 2014). Oldani (2014) found some US psychiatrists that, as a response to these tendencies, were re-evaluating patients that had been treated by primary care physicians, modifying their diagnoses and decreasing the number of medications they were taking.

On the patient's corner, anthropologists have depicted several instances of resistance and anxiety towards psychiatric drugs, focusing on specific effects they have on subjects or general disaffection towards them because they do not bring the improvement that is wished for. Women in a small village in Brazil, for example, are prescribed benzodiazepines for severe anxiety problems but largely choose to avoid them because they are afraid of heavy side effects and of not being able to work (Leibing and Collin, 2013). Pope (2015), on the other hand, writes about female youth in residential treatment that also judge psychopharmaceuticals negatively but end up sliding into "medicalised selves", developing a degree of expertise in the matter and inhabiting "bipolar identities". Béhague (2016) also provides an illustrative example

regarding Brazilian youth that are initially referred to psychologists at their schools. She describes a context where both patients and therapists are keen on avoiding a pathologising recovery framework and see medications only as a temporary aid on the path towards improvement. However, through longitudinal analysis, she detected a stark difference in the course of medication-taking among the well-to-do and poor adolescents. Without the multifaceted treatment and social support of the upper classes, underprivileged kids eventually returned to the clinic in early adulthood and, after failing to fight their way out of their personal problems and changing the unequal society they live in, ended up sliding into biomedical readings of their situation and chronic medication use.

In addition to the subjective experience and course of drug treatment, anthropologists have also depicted the social meanings of psychopharmaceuticals. Once they enter social settings, pills stop being the biomedical artefacts that have been created by psychiatry to treat clinical depression and acquire new meanings and forms bred by the interjunction of “modernity” and local worlds. Ecks (2014), for instance, shows how psychiatric drugs come to inhabit a context rife with popular health notions and medical traditions—biomedicine, Ayurveda, and homeopathy—that interact with each other and influence how these biomedical objects are regarded and used. Even psychiatrists are mindful of the importance of popular health culture, as they discard biomedical discourse and take on socially relevant metaphors in order to increase treatment adherence.

## How to Close the Gap: Towards an Improved Global Mental Health

There is a flourishing anthropological literature that is contributing to the global mental health debate and offering theoretical and methodological proposals of how to improve policy efforts and provide access to quality mental health services to the world's sufferers.

Several authors have written about how the Global Mental Health (GMH) movement rose into the spotlight in recent years and has been met with criticism from anthropologists and cultural psychiatrists (Bemme and D'souza, 2014; Kirmayer and Pedersen, 2014; Orr and Jain, 2016; Kohrt, Mendenhall, and Brown, 2015; Bartlett, Garriott, and Raikhel, 2014). Having defined their mission as an urgent crusade to

provide treatment to the world's neediest countries, the movement—critiques say—is uncritical of the type of solution it is exporting. References to social and cultural context of mental illness remain peripheral in relation to GMH's main component, biomedical psychiatry, and interventions are generally reduced to psychiatric diagnoses and pharmacology, which is seen as a narrow solution to problems embedded in unfavourable socioeconomic and political contexts (Kirmayer and Pedersen, 2014, p. 765; Summerfield, 2014, p. 408). We should take note, however, that GMH advocates have subsequently acknowledged a troublesome dependence on psychiatric nosological classification and pharmacological treatment, and expressed the need to broaden the movement's purview (Ecks, 2016).

GMH critiques first call into question psychiatry itself. The production of evidence that supports it in the West has been heavily influenced by the pharmaceutical industry and it is highly contested. Furthermore, psychiatric diagnostic labels have been known to affect individuals' sense of personal agency and can lead to stigmatisation and chronicity. A second critical argument against GMH is that it has centred efforts on delivering individual treatment of mental health problems, losing sight of the social determinants that should be addressed in order to generate living environments that allow individuals to enhance their well-being. Finally, the movement has been chastised for championing a standardised Western mental health model that is culturally incompatible with many contexts and indifferent to local conditions, leading to a top-down approach that ignores local explanatory models and therapeutic resources. Ecks (2016) and Bartlett, Garriott and Raikhel (2014) argue that the "treatment gap" discourse obscures local contexts because it portrays them as empty vessels, when in fact they are composed by complex assemblages of actors and institutions that deliver mental illness treatments in specific ways.

The cultural critique of psychiatry that stresses the need to take the local into account has held a presence within anthropology ever since Kleinman (1977) flagged the emergence of a "new cross-cultural psychiatry" and Nichter (1981) proposed an "idioms of distress approach", and it has been the object of prolific academic production. Anthropology has set out to dismantle the assumption that Western mental disorder nosology is universally applicable to any social context and has advised that psychiatry should acknowledge a varied set of contextual issues such as local recovery models (Read, 2012), perceptions of drug side effects (Lee, 1993), local physiologies

(Lin, Poland and Lesser, 1986; Ninneman, 2012), help-seeking pathways (Khoury et al., 2012; Cooper, 2016; Orr, 2012), and alternative healing options (Sax, 2014; Quack, 2012; Sood, 2016; Lang and Jansen, 2013).

However, some authors argue that the cultural critique of psychiatry should not be turned into a wholesale critique of the discipline that creates an insurmountable impasse between global mental health champions and cultural specialists. Instead, anthropology's specialty, ethnography, can be put at the service of the GMH movement by evaluating specific experiences and suggesting how to improve the policies that seek to expand mental health treatment coverage. That is, anthropology should transcend its traditional position at the sidelines and become a collaborator in the world of mental health policy. Some anthropologists are starting to do just that. By looking in detail at different instances of the policies promoted by the GMH movement, they are pointing out the barriers encountered by scaling-up efforts, as well as paying attention to stories of successful programmes which are effectively enhancing access to mental health services. It should also be noted that most of the general critiques made to the GMH agenda are mirrored in these accounts.

Good and Good (2012) highlight how China's national programme of mental health services reform—the 686 Project—is relying on implementation research carried out by local mental health teams to build a comprehensive national database of local experiences. This effort, they argue, is of key importance for the development of fine-grained mental health policy and allows the replication of models in other low and middle-income countries. Regional innovations that occur within national mental health programmes are of value in this process, and so policy makers should shed the excessive standardisation that characterises global health practice and “encourage the development of multiple models of mental health care” (Jain and Jadhav, 2009, p. 78).

The poster child of GMH policies is the task-sharing—or task-shifting—initiative, which consists of integrating mental health functions to primary care and community settings via non-specialist health personnel and lay people. The integration of mental health into primary health care was first put forward by the WHO in the 1970s and 1980s, but it failed to gather the momentum necessary for widespread implementation among low and middle-income countries. Advocates of the strategy promote it as a way of enhancing access to the care of common mental health problems in low and middle-income countries where mental health specialists are not widely available (Patel et al.,



2013, p. 1). Integrating mental health services into other health care platforms also offer the advantages of coordinating general and mental health care more effectively and reducing the fear of stigma that patients and their families usually associate with specialised mental health treatment settings (Patel et al., 2013, pp. 1-2).

Studies caution, however, that usual deficiencies found in local healthcare platforms of low and middle-income countries can posit obstacles to the implementation of task-sharing interventions and thus need to be addressed. Factors such as the inadequate funding of services, lack of infrastructure and human resources (Patel et al., 2016, p. 3077; Mendenhall et al., 2014, pp. 37-40), and stigma towards mental health patients (Patel et al., 2016, p. 3079; Mendenhall et al., 2014, p. 37; Burgess 2016, pp. 728-729) may hamper the success of programmes. The acceptability of task-sharing by healthcare staff has been identified as a key element to take into account when trying to implement an intervention (Mendenhall et al., 2014). Witnessing how task-sharing models benefit services and patients may enhance acceptability among frontline health personnel (Patel et al., 2013, p. 2; Pereira et al., 2011, p. 8). Additionally, staff should be recognised and compensated for the new roles they are assuming in order to increase the feasibility of the intervention (Mendenhall et al., 2014, p. 40).

Patel has stated that a “collaborative care framework” is the most evidence-based task-sharing system of mental health delivery. His organisation, Sangath, has proven through randomised controlled trials that this model benefits patients who suffer from dementia, schizophrenia, and common mental disorders such as depression and anxiety in India (Patel, 2015, p. 22). The collaborative care framework includes mental health specialists, professional non-specialists, and lay health workers. Specialists should play the role of public mental health leaders; designing and managing these programmes, training and supervising non-specialists who are engaging in mental health tasks, and being available for consultation and referrals (Patel, 2009). Non-specialists (professional and non-professional) can act as case managers (Pereira et al., 2011, p. 9), offer psychoeducation (Patel et al., 2011, p. 460), undertake medication management and psychotherapies (Patel et al., 2013, p. 3), and social interventions such as “befriending, providing practical help for economic difficulties, mobilising and strengthening existing non-biomedical sources of help that are contextually acceptable (such as spiritual interventions in some places) and promoting self-help delivered through books or the Internet” (Patel, 2014, p. 18).

Anthropologists have also discussed how the ideal model of task-sharing training may look like. Consensus seems to be forming around the “apprenticeship model”, in which care providers are trained theoretically and practically, under supervision, for a specific period of time (Kaiser and McLean, 2015). In order to pull this off, however, programmes need a number of trainers that is not usually available in low and middle-income countries. Thus, Good and Good (2012, p. 175) write about how China is building “a cadre of teachers to run a wide variety of courses for all types of personnel who manage or provide services for the mentally ill” and Kohrt and Jallah (2015, p. 261) describe how a task-sharing program from the Carter Center trained 150 mid-level mental health clinicians from Liberia in a lapse of four years.

Task-sharing with local lay health workers has gained special momentum. This sort of action uses “available human resources” (Patel, 2015, p. 22) such as motivated and skilled people who are not health care professionals, or people who have been affected by mental illness (peers). It is an “affordable and contextually sensitive” care delivery model (Patel et al., 2016, p. 8). Kaiser and McLean, for instance, argue that “local community members may be ideal for task-sharing initiatives because they are more knowledgeable about local explanatory models and cultural concepts of distress” (2015, pp. 283-284). Using local idioms of distress, they say, can make the training of lay health workers more culturally relevant, facilitate the detection of locally meaningful problems that standardised screening instruments can miss, and improve treatment outcomes (Kaiser and McLean, 2015, pp. 281-285). In addition to these valuable aspects of lay task-sharing, it also frees up time for healthcare professionals that are able to undertake mental health-related activities with more ease (Pereira et al., 2011, p. 8). In the case of peer providers, Myers (2015a) argues that, since they have gone through similar experiences of illness and eventually recovered, they are better suited to deliver care. They understand patients better and can become role models, and the experience can be a source of self-satisfaction and purpose for peer carers themselves and may be helpful in the prevention of illness relapse.

But mental health policy is not limited to the integration of mental health to primary care and community settings. Varma (2016) illustrates some of the blind spots of the task-sharing agenda in her article about India’s policy of transforming mental asylums into modern training and research centres. If task-sharing is an answer to a shortage in specialised mental health professionals in low and middle-income countries, then what

if policy makers were to promote the generation of more specialised manpower as well? Recently, India has started to transform eleven mental hospitals into regional “Centres of Excellence” that will inject a substantial amount of specialised mental health professionals into the health system. Varma (2016, p. 786) considers that this initiative and task-sharing are contradictory models that co-exist in tension within India’s National Mental Health Programme. Jain and Jadhav (2008, pp. 578-579) mention the creation of specialised satellite mental health clinics in India but see them not as co-existing in tension with primary care task-sharing programmes, but as replacing them due to their failures. Good and Good (2012, p. 175), similarly, differentiate decentralised multifunctional treatment teams practicing mental health full-time in China from the older model of training primary care doctors and nurses, and view this strategy as expensive but more effective.

The second of the blind spots identified by Varma refers to how the effort to convert mental hospitals into modern research centres in India exacerbated the exclusion of the chronically ill. The chronic wards of the hospital she observed did not receive any funds from the programme and continued to be ignored by psychiatrists. The chronic subject and his or her identification with the custodial model of psychiatric care did not fit in the new narrative of modernisation and, thus, the question of how to improve the care of these patients remained in neglect. A similar point is raised by Good and Good (2012, p. 175) when they highlight that the China programme includes a focus on rehabilitation and recovery, unlike “older models focused more narrowly on the management of psychotic symptoms”. Furthermore, preventive mental health programmes are almost absent in the anthropological literature. For example, initiatives that seek to reduce mental illness stigma (Kohrt and Harper, 2008) or programmes that focus on preventing disorder by strengthening resilience in preclinical populations (Friedman-Peleg and Goodman, 2010).

Finally, anthropologists have discussed different aspects of therapeutics that hold relevance to the global mental health agenda. De Jong (2014) and Kohrt and Jallah (2015) bring up multiple arguments in favour of reconsidering the role and usage of psychopharmaceuticals in primary care settings. In countries where mental health functions are more consolidated within primary care, there is a serious over-prescription problem that has not yet been tackled. Furthermore, psychiatric drugs need to be dispensed along with indications and their use and side effects need to be carefully

monitored, requirements that most primary care settings in the world are probably not prepared to fulfil. In addition to this, countries with little regulation capacity and under-resourced health systems have problems preventing the illegal dispensing of psychopharmaceuticals and the chaotic use that poor segments of the population make of them—for example, the fluctuation between moments of taking too many meds and moments of not taking them at all.

Given these concerns and rising uncertainties about the effectiveness of psychopharmaceuticals, authors call for increased attention in psychotherapies and alternative healing. Psychosocial treatments remain marginalised in task-sharing programmes, but complex interventions—such as cognitive behavioural therapy and others—and basic psychoeducation and counselling are effective means that can be adapted to local settings (Kohrt and Jallah, 2015, p. 272; Kaiser and McLean, 2015, p. 284). Alternative healing has also been traditionally marginalised in the public health arena, even though it enjoys high demand in both low and high-income countries and a high proportion of mental illness sufferers use it. In low and middle income countries they are geographically and culturally accessible and provide valuable psychosocial support. They are in a privileged position, then, to participate in identification, treatment, and prevention activities (de Jong, 2014; Myers, 2015a; Burgess, 2016; Jain and Jadhav, 2008).

Anthropology has also produced a substantial amount of assessments of actual culturally relevant practices in psychiatry. Poltorak (2016), for instance, writes about the lessons that global mental health can take out of a Tongan psychiatrist's successful public mental health project. The most remarkable aspect of his project has been the anthropological understanding of local conceptualisations of mental illness and the “cultural brokerage” between psychiatric and indigenous knowledge. He has been able to make psychiatry more effective by translating it into the language of traditional healing and everyday discourse. These and other anthropological contributions constitute valuable references for the GMH movement.

### Setting and Methodology

Lima is a metropolis of over nine million people, less than a third of Peru's population. It is by far the largest city in the country due to the massive waves of migration that have

been taking place since the 1940s. People have migrated to Lima mostly looking for job and educational opportunities or escaping the armed conflict between Maoist guerrilla group Shining Path and the government in the 1980s and 1990s (Golte and Adams, 1990, pp. 38-48; Comisión de la Verdad y la Reconciliación, 2003b, pp. 640-641). Figure 2 shows the position of the affluent creole population in purple—although migrants that have fared well economically have also moved into these areas—and the migrant population that has progressively stretched Lima's size to the north and south. The map clearly portrays economic inequality, with poverty getting worse as it goes further along the margins.

Figure 1 shows where Lima's three psychiatric hospitals are. Most mental health professionals from the public sector are found within these hospitals. With the last one of them having been opened in the early 1980s, the map shows that the city has grown a lot since then and, as a consequence, some population segments live very far away from the hospitals. Patients do not only arrive at the hospitals from Lima, but also from other regions, which speaks of the need for decentralised mental health services to be implemented throughout the country. Patients are mostly from the low and middle income population sectors, while psychiatrists are part of the upper echelons of the socioeconomic structure.

I carried out fieldwork for over a year, from April 2012 to July 2013. As I have mentioned, I chose Hospital Valdizán and Instituto Noguchi as my field sites because they are the most progressive institutions. Both have community psychiatry traditions and, at the time of my fieldwork, were implementing programmes that sought to create new mental health services beyond the walls of their institutions, in general hospitals and primary care centres (Chapter 3 and 4). On the other hand, Hospital Larco Herrera has been known for having a huge abandoned patient population and organisational politics that are quite complex and resistant to change. When I interviewed a veteran psychiatrist in an outpatient consultation office of the hospital, she told me that Larco Herrera was the only “manicomio” in the country. She used this word because, although it literally means psychiatric hospital, it has a negative and backwardly connotation. Another interesting aspect of Hospital Valdizán and Instituto Noguchi is that they were the projects of Humberto Rotondo and Javier Mariátegui, two Peruvian psychiatry luminaries of the twentieth century.

My plan within the hospitals was to follow psychiatrists in their daily routines

(shadowing). Since I wanted to observe “normal” hospital psychiatry and alternative kinds of practices linked to community psychiatry and reform projects, I chose participants from different areas of the hospital (outpatient areas, hospitalisation wards, community mental health departments, etc.). The specific way in which I picked psychiatrists in hospital areas varied according to each context. Community mental health departments are small, for example, so there are not too many practitioners to choose from, whereas at hospitalisation wards I chose the ones who most fitted my schedule (I worked a couple of days a week at a university).



Figure 1. The location of Lima’s three psychiatric hospitals.

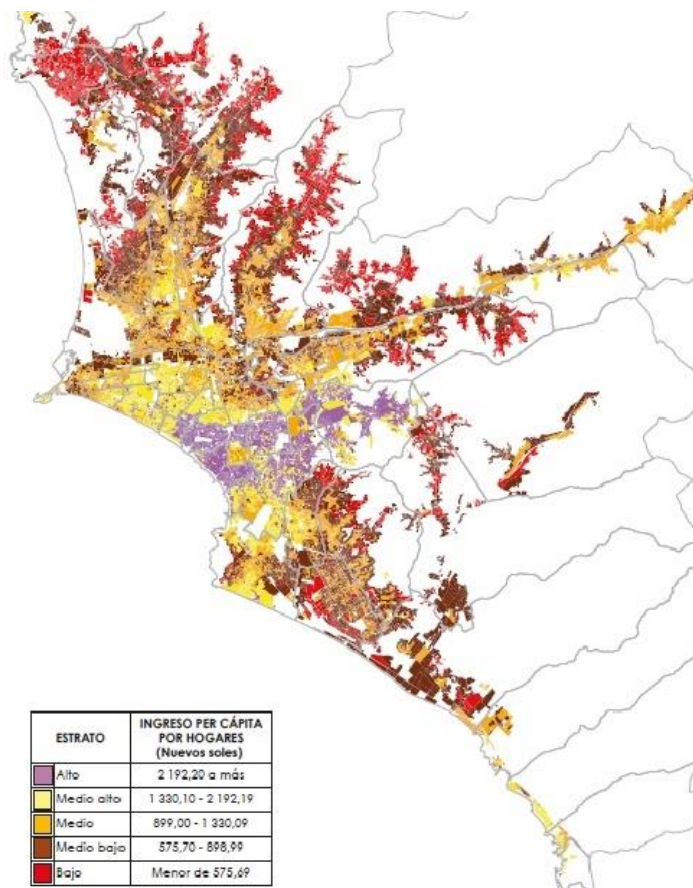


Figure 2. Income per capita map of Lima (INEI, 2016, p. 14).

I worked with six psychiatrists from each institution, although I just shadowed the ones from Hospital Valdizán because I was not given permission to do so at Noguchi. I have given priority to Hospital Valdizán when analysing hospital psychiatry because the data obtained there is richer than the one obtained through interviews at Instituto Noguchi. I did include, however, Noguchi's community mental health area in my analysis because I was able to obtain more access to it, interviewing many of its members and visiting its practicing sites. I still was not able to shadow these practitioners so the data is more limited than the one from Hospital Valdizán's community department.

The shadowing method allowed me to witness multiple instances of the psychiatric routine at hospitalisation wards, the outpatient area, and the community mental health department. I observed and participated in hospital rounds, clinical team meetings, family interviews, moments of informal hanging out, electro-convulsive therapy

sessions, car rides to the community mental health centre, consultations, training sessions at primary care centres and general hospitals, home visits, and group sessions with chronic patients. In these events I observed practices, interactions among peers and other actors, the training of residents, and everyday language and concepts that revealed more general assumptions about psychiatric practice, patients and mental illness.

In addition to shadowing, I carried out semi-structured interviews that lasted between one and two hours with my psychiatric subjects, as well as engaging in informal conversations whenever the circumstances allowed it. I also held interviews with psychiatrists that were not in my sample, hospital authorities, residents, and other mental health professionals. Moreover, I contacted four veteran psychiatrists outside of the hospitals to get an external expert outlook on Peruvian psychiatry. These were knowledgeable and reflective subjects who provided helpful insight. My interviews spanned a diversity of domains such as psychiatric practice, training, research, hospital politics, and the history of Peruvian psychiatry. Finally, I carried out observation and interviews with other actors such as service users and family organisations, and an advocacy group for mental health reform.

A limitation of this study is its limited representativeness. That is, the small number of main psychiatric informants in which it is based cannot be said to fairly represent the whole universe of Peruvian psychiatrists, or even the whole universe of practitioners within the hospitals of the study. The reason why I chose a small sample of key informants, instead of observing a wider array of psychiatrists in the hospital, was that I wanted to focus on specific individual styles of practice and how these related to practitioners' views and activities within and outside the hospitals. In other words, I wanted to observe individuals, not just faceless hospital practices.

Another limitation of my methodology is how I handled patients. Instead of observing them as individuals, as I did with practitioners, I paid attention to them in an impersonal way, insofar as they interacted with psychiatrists. Thus, reference to specific patients will be rather limited throughout the study. I did, inevitably, see their behaviour and reactions when they interacted with my informants, but I did not delve more into this by talking to them about it. This can be seen as a limitation to the extent that interviewing patients would have provided me an important take on the actions of my research subjects.



I am somewhat familiarised, however, with the plight of patients and their hospital interactions. Between the months of July and September of 2007, I interviewed six Hospital Valdizán patients and their closest family members for an assignment during my undergraduate anthropology degree in Peru. The interviews, which were carried out in their homes, lasted between one and two hours and focused on the patients' illness trajectories—from their first psychotic episode to the present—and how they and their families had coped with schizophrenia over time. The afflicted were at different moments of their illness—some had recently experienced their first crisis and others had several years of illness experience—and most of them lived with their siblings and/or parents (only one was married). I also interviewed some of the mental health professionals—psychiatrists, nurses and social workers—from Hospital Valdizán who were familiarised with these patients and analysed their medical charts. I will use some of this earlier information when generally discussing how patients and their families cope with mental health problems and their perspectives on hospital treatment.

In terms of my rapport with informants, my condition of local academic researcher placed me in a position of certain affinity. I have lived in Lima my whole life so I knew the culture and language well and, although some of the psychiatrists involved were born elsewhere in the country, they are all professional urbanites identity-wise, not too dissimilar from myself. An anthropologist is an outsider in the hospital, however, and although I already had a degree of familiarisation with this milieu from a previous experience, psychiatry is a highly specialised field with a whole set of opaque terminology, ideas, and practices that I had to decipher during the course of my fieldwork.

My alien presence was camouflaged by the white coat I was required to wear (I also had to get a student ID card). It was only required to get into the hospitalisation area because other sites are open to the public at Hospital Valdizán. An auxiliary nurse from the community department gave me a spare coat he had, so I ended up wearing a nice one with the hospital's logo on its pocket. The white coat normalises the presence of a foreign person. You get to walk past the hospitalisation gates without being asked any questions and you talk to people without receiving a look that makes you feel like you do not belong there. It means that you have a legitimate reason for being there, you are some sort of student doing something, and anyone asking what you are doing exactly depends if they have the time and interest to know.

The psychiatrists from my research were, for the most part, kind and considerate towards me. At Hospital Valdizán I was able to spend time with them and their cliques and, as a consequence, develop friendlier relationships. This was especially the case in the community department because work there consisted of going by car from the hospital to a community mental health centre, and this allowed for plenty of informal chat to take place. I found this to be most beneficial in the case of a practitioner who at first had an avoidant attitude towards me. I was able to gradually build rapport with him and we ended up having a friendly relationship. This did not happen with a ward psychiatrist who accepted to participate but, without expressing it explicitly, did not seem entirely comfortable with my presence. During my shadowing of his practice, he acted as if I was not there, and I sometimes had trouble hearing what he talked about with residents because he spoke very softly. The wards afforded me less spare time to mingle and build rapport with psychiatrists, possibly making it harder for this relationship to become friendlier as the one in the community department setting did. Thus, in this case, the level of access that I obtained towards an informant was limited by his apparent low acceptability of my presence.

In order to access Hospital Valdizán, I contacted its Research Department and was instructed to present my research proposal to the hospital's ethics committee, which took some months to reply positively. Before entering the hospitalisation wards and outpatient area, I visited the head of these areas to tell him about my research and see if he had any advice or useful information. Then I proceeded to contact the psychiatrists I was planning to follow, giving them an informed consent form as the hospital required. Response to informed consent was varied, some did not give it much consideration, others asked for further verbal explanation of my research, and only one asked about my research proposal. These reactions probably reflect the varying degree of interest in my research topic.

A second level of access into hospital practice depended on psychiatrists themselves, who decided what I could and could not witness. There were a couple of instances in which I was denied access to a space because it was considered off-limits. One was the psychoanalytic consultations of a practitioner, which were considered too intimate for me to be in, and the other was a political negotiation meeting between the head of a department and the hospital's labour union representatives. A couple of psychiatrists also felt uncomfortable in situations they judged as unfavourable for their

practice. This happened with task-sharing training sessions in primary care centres where health personnel lacked motivation, and with normal consultations. One practitioner initially did not want me to observe him at Hospital Valdizán's outpatient area because he regarded consultations as too time-constrained, although he loosened up once we became more acquainted with each other. In this sense, some informants precluded my access to spaces where their practice was challenged by difficult conditions, although I was able to negotiate this with one of them.

Access to Instituto Noguchi was a different story. I was not even allowed to apply because they follow Ministry of Health rules more strictly than Hospital Valdizán. Officially, an “internship”—as they called it—can only be done by someone from a university department that has a signed agreement with the hospital. The person in charge of overseeing my case at Noguchi did not want to turn me down—he was attentive and even granted me an interview about psychiatric research at the hospital—, but he had his hands tied due to legal problems they have had with past internships. At the time, Noguchi only had a signed agreement with a local medical school, which means that only doctors can do research within the national institute of mental health. This should be modified in the future in order to open up the field of mental health, which has remained an exclusive space of psychiatrists.

This mishap prevented me from shadowing psychiatrists there and that is why I have not included Noguchi in my analysis of hospital psychiatry. I did not want to completely drop the place from my research, however, and proceeded to contact psychiatrists that work there for interviews (I was told that I was free to do this). Three practitioners declined, something that had not happened at Hospital Valdizán. One told me that “institutional information can only be given by the director” and another thought that he could be suspended if he said something against the institution's official policy. “Our bureaucrats worry about us saying something against state policy,” he said.

By contrast, staff members from the rehabilitation and community mental health departments were more open towards me. At the former, an invitation to their community-based rehabilitation activities was offered without me asking for it. The same happened with a community psychiatrist who suggested I should watch the group meetings he held with patients in a primary care centre. And one of my longest interviews was when I visited a nurse from the community mental health area at a primary care centre. I can only speculate about the reasons for this difference between

community mental health staff and hospital psychiatrists. My impression is that they were eager to be heard and observed due to the marginal position they hold in the institution. Moreover, they seemed to have a good opinion about anthropologists and felt that I would appreciate their practice.

In terms of my interaction with patients, the hospital did not require me to give them informed consent forms as I had to do with psychiatrists, the main subjects of my study. I had previously submitted an ethical review form to the Research and Research Ethics Committee of the School of Social and Political Studies at the University of Edinburgh, where I stated my intention to seek the verbal consent of patients. I was not able to maintain this standard to its full extent while on the field, however, as I will discuss in the following lines.

Qualitative researchers have discussed the ethical quandaries that can arise unforeseen when the pledges that the researcher had previously made run into obstacles in the actual relationships of fieldwork (Oye, Sorensen, and Glasdam, 2016, p. 462; Baarnhielm and Ekblad, 2002, pp. 471-472). “Those promises can sometimes be easier to make than keep,” admonish Fine and Shulman (2009, p. 179). Falling short of the conventional ethical norms of research in health settings, such as informed consent, can generate moral anxiety in the researcher who feels unsure as to how to conduct himself in the concrete situations that he encounters during fieldwork (Skultans, 2005, p. 495; Marzano, 2007, pp. 419-421). Nordentoft and Kappel (2011, p. 371) go so far as to say that we should consider researchers of vulnerable groups potentially vulnerable themselves due to the high moral stakes of their dealings with staff and patients.

There are some qualitative researchers that have specifically reflected on the topic of what to do about people who are not the research’s main subjects of study, but who partake in its action as “accidental participants” (Franklin et al., 2012, p. 1734). Do we have to state our identity to them under any circumstances or is it sometimes acceptable to deceive by omission (Fine and Shulman, 2009, p. 187)? And what should our disclosure of identity entail? For starters, it is commonly a challenge to provide information about your research to a secondary participant (Franklin et al., 2012, p. 1734), so instead of informed consent, we should talk about plain consent. The ethnographer is in a space and situation that is predominantly managed by a powerful gatekeeper such as the psychiatrist, and most of the time it is this actor who is in

charge of telling the patient who you are. Naturally, he or she may not have the capacity or willingness to explain your endeavour in a careful manner. In this sense, what is in place is a “hierarchy of consent” (de Laine, cited in Marzano, 2007, p. 427-428), where how informed participants are depends on how central they are to your study.

In addition to informing the secondary participant, however, there are other potential reasons for disclosing the researcher’s identity. The first one is known as “role-conflict” (Fine and Shulman, 2009, p. 187): the situation where the secondary participant thinks that the researcher is playing a role that he is not—for example, that he is a doctor. This can potentially mislead service users into thinking that the researcher can help them in ways he cannot. Personally, I avoided this peril by not directly interacting with patients or their families, a dynamic I managed to achieve successfully.<sup>5</sup> A second reason is related to paying respect to the patient’s wishes and improving the conditions of his or her clinical encounter. It entails not just disclosing the researcher’s identity but asking for permission to be there. This may be most pertinent in cases where patients are distressed or embarrassed about what they have to tell.

This is not a popular topic in the literature, but among the authors I have consulted, opinion is divided as to how important securing consent with accidental participants is. On the side of the deniers, we have Fassin (2006, p. 524) who expresses the following position:

In a discussion with my South African colleagues about our collaborative study of health professionals, I wondered what practical utility the extension of informed consent to patients as well as health workers would have had. It seems no different to me than if, when I went out at night with the police in the suburbs of Paris to analyze their interaction with youth, mostly blacks and Arabs, during the past year, I had explained the objectives of my research and gotten informed consent from young men during their identity check and body search, hands on the roof of their car, legs spread wide.

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<sup>5</sup> I am not taking into account here my 2007 interviews with patients and families, which involved a regular informed consent process. This early experience showed me that, even if you carefully inform people of your research, role-conflict can still ensue. They can keep calling you “doctor” even though you have told them that you are an anthropologist, and they can expect you to have more biomedical knowledge than you do, or help them in ways that exceed the purpose of your research. What I did in these cases is provide the help that I could and continue to underline that I was an anthropologist conducting research.

Fine and Shulman (2009, p. 187) downplay the importance of the matter by calling the non-disclosure of the researcher's identity to accidental participants as a secondary deception, a primary one being lying to the organisation where you are conducting your ethnography. Others portray this kind of ethical fault as the cost of a benevolent bargain. Skultans (2005, p. 495) states that, beyond the traditional ethical concerns of the researcher, she felt more "moral discomfiture that some psychiatrists were promoting an account of patients' distress that was totally at odds with the patients' views of what was wrong and why and, indeed, with my own perceptions." Nordentoft and Kappel (2011, p. 374) highlight the importance of considering how the research can benefit patients as a way out of the conundrum of balancing research interests and ethical considerations. And Marzano (2007, p. 428-429) argues that the "harmful effects on the ill of sociological research like mine are not nearly as significant as the positive effects deriving from better understanding of their daily lives", and asks rhetorically: "What harm could be caused to the ill by breach of the rules on informed consent by a social researcher if those same rules are applied by doctors and other health practitioners only on paper?"

On the side of the advocates for informed consent for accidental participants, Franklin et al. (2012, pp. 1734-1736) advise that it is important to comply with this norm when possible because a doctor's behavior cannot be observed independently of patients' reactions. There are situations, however, when asking for informed consent might be practically difficult or inappropriate. Fassin (2006, p. 523) mentions that doing this with severely ill patients is not feasible or humane. This applies to the hospitalisation wards at Hospital Valdizán, where I am sure doctors would not see fit to ask patients who are in an acute state of mental distress about partaking in my research. Moreover, the nature of the encounters with ward patients—short successive interrogations with the participation of multiple actors—makes it impractical to ask for everyone's consent on the spot.

In addition to these factors, my presence made less of a difference compared to individual consultations because in the wards I was one in a group of many, including people just observing. Moreover, aside from the doctors and residents, the presence of other personnel present in the patient rounds was not fixed, it was common to see new faces appear. Thus, there is a lower risk of making the patient feel uncomfortable, or more uncomfortable than he or she already is. Lastly, even if the researcher finds a way

of asking all of the ward patients for consent, given that rounds include all of them successively, it is difficult to selectively avoid the ones who have not given their consent. Oeye, Bjelland, and Skorpen (2007, p. 2298) corroborate this: “It was not practically possible to avoid observing situations in which patients who had not given their consent were involved.” They argue that this problem arises from the contradiction between informed consent as an individual-based ethical guideline and participant observation as a collective approach based on observing interaction between participants (Oeye, Bjelland, and Skorpen, 2007, p. 2304).

In the case of individual consultations, I told psychiatrists—except for one who told me first that he would be doing this—that I wanted to ask for patient permission in consultations, but I soon found out that this was not a straightforward task either. Some of the values contained in the informed consent philosophy may not be shared by the actors inhabiting local hospital cultures. Skultans (2005, p. 498), for instance, illustrates how the value of privacy cherished in the West is not present in Latvian psychiatric consultations, which tend to include more people and where personal problems are publicly shared. Marzano (2007, p. 418), for his part, explains that in Italy the value of independent decision-making is overshadowed by a paternalistic medical culture. The moral variability of these settings is, according to the authors, an obstacle to the successful implementation of informed consent.

In my first experience at Hospital Valdizán in 2007 there was some evidence that informed consent protocols were not taken seriously by some practitioners.<sup>6</sup> However, I was not in a position to determine the extent to which this constituted a generalised culture within the hospital. In the present study, psychiatrists had different attitudes towards my proposition of asking for patient consent. The first answer I got was that it was not necessary because patients are used to this type of situation given that Hospital Valdizán is a teaching hospital. In fact, psychology interns from the community department joined me in observing consultations on two occasions. In any case, I told this practitioner that I still wanted to ask for permission and did not encounter any

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<sup>6</sup> A psychiatrist had offered me to contact a family for my research and I told him that I wanted to wait for their next appointment at the hospital, rather than calling them in exclusively for my research. Exhibiting a peculiar take on informed consent, he replied: “Don’t worry, we call people all the time for clinical trials, it’s easy to make them participate.” The other worrying instance was when a family told me they had not been asked for consent before applying ECT to the patient. Formal hospital norms established that family members have to give their consent for ECT.

problems there. Another psychiatrist also allowed me to ask for permission, but only in the case of new patients. He told me that “continuing” patients would not be bothered by my presence, that they are commonly more relaxed, so it only made sense to ask the new ones. These two examples illustrate how psychiatrists, based on their interpretation of local reality, can make alternative recommendations about patient consent.

Furthermore, the solicitation of patient consent takes place within a context of unequal relationships among ethnographers, doctors, and patients. Doctors dominate this relational space and frequently act as the gatekeepers of informed consent (Mueller 2004, p. 44). Patients can be influenced by doctors when taking their decision because they trust them or because they feel pressured (Aldred, 2008, p. 895; Franklin et al., 2012, p. 1734; Addlakha, 2005, p. 55). Oye, Sorensen, and Glasdam (2016, p. 459) conclude: “Therefore, the dominating research ethical ideal of a noninfluential milieu based on the ideal of free choice seems rather naive when doing qualitative research.” Doctors may also fail to keep their promise of asking patients for permission or they may ask for it in a way that does not satisfy the researcher. On one occasion, one of my subjects who had taken upon the task of asking for patient consent told the patient: “This is Juan, he is working with me.” This was clearly not a consultation, but a notification. I talked to him afterwards about this matter and he agreed to change his wording in the future.

Thus, local conditions and fieldwork relationships generated unforeseen ethical dilemmas that forced me to accommodate myself towards my informants and negotiate new consent procedures. I am aware that negotiating with powerful informants is not a simple task and that it probably depends on how your relationship with them develops. Authors have pointed out that fear of offending may impair an ethnographer’s willingness to question healthcare staff and their actions (Anspach, 2006, p.717), and that pushing against the way things are done may place the research enterprise at risk (Skultans, 2005, p. 498 ; Marzano, 2007, pp. 426-427). Ultimately, moral perfection—the ideal ethical conventions—cannot always be attained, but in these instances the ethnographer can undertake a moral analysis and decide for the next best course of action.



Finally, alternative informed consent procedures that better suit the exigencies of qualitative research and hospital settings can be considered. For example, Oeye, Bjelland, and Skorpen, (2007, p. 2305) suggest that patients be included in the hospital research councils that approve research projects in order to make ethnographies in collective settings, such as wards, more legitimate. Empowering patients within the hospital could also be a road towards promoting their role in overseeing the compliance with informed consent procedures among professionals.

## Mental Health Reform: Policy and Governance

In a report about the progress made by Latin American countries fifteen years after the Pan American Health Organization's (PAHO) mental health conference in Caracas<sup>7</sup>, Caldas de Almeida (2007, pp. 23-26) asserts that nearly 90% of them have developed national mental health policies and plans, but few have been successful in effectively implementing them. In this chapter, I will analyse the efforts that have been made towards achieving mental health reform in Peru and the institutional and political dynamics, at different levels of the mental health system, that form the background for these actions. The chapter will be divided in two sections: a brief history of mental health public policy in the country and an exploration of the reform efforts made by a PAHO-sponsored civil society advocacy group.

### Mental Health Policies since the 1950s

Before I start reviewing the recent history of mental health policies in Peru, I want to describe the general characteristics of the current mental health system. Historical facts are taken mostly from Bustamante (2009), but reflections are my own.

The key marker of unachieved mental health reform has been the centralisation of services in a small number of psychiatric hospitals. Most mental health professionals and psychiatric beds are concentrated in Lima's three Ministry of Health psychiatric institutions (Defensoría del Pueblo, 2009, pp. 100-107). These and a small number of psychiatric outpatient units at general hospitals, mostly in Lima, have been the only

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<sup>7</sup> The Caracas conference in 1990—called "The restructuring of psychiatric treatment within local health systems"—was the first of three events sponsored by the PAHO where most Latin American countries pledged allegiance to a set of principles that were to be put into practice in the form of mental health policies and plans. One of the main concerns put forward was the monopolisation of mental health services by psychiatric hospitals and the need for them to branch out into general medical services and alternative community facilities.

public mental health services available in the country. At the primary care level professionals do not detect, treat, or refer mental health problems.<sup>8</sup> In addition to their work in the public sector, most psychiatrists have individual private practices or work in some sort of private clinic.

This excessive centralisation of mental health services has two implications. First, psychiatric hospitals have been unable to function optimally due to being overwhelmed by an excessive patient demand that flows in from multiple districts of the capital. Secondly, the global treatment rate of the population's mental health problems has been quite low. According to Saavedra (2012, p. 33), the number of people who need treatment and actually get it varies from 13.9 to 24.3% in different parts of the country.

Psychiatrists have remained within hospital limits, in control of their own institutions but not deciding the fate of the mental health system. While it has remained elusive at the systemic level, reform has been effectively accomplished within the hospitals. In Hospital Valdizán and Instituto Noguchi, for instance, psychiatric treatment has been modernised. The old ways of mental institutions have been replaced by shorter hospitalisation times and humane care, and innovative services in the fields of psychotherapy, rehabilitation, and community mental health have been developed. Hospital Larco Herrera has been a harder nut to crack, however. The Ministry of Health had to impose reform there on two occasions (1994 and 2004), when new directors were assigned and given the task of refloating the hospital from the state of misrule in which it had fallen.

Nevertheless, there have been plenty of attempts by psychiatrists aiming at mental health reform beyond the hospitals. In this first part of the chapter, I will review these, how the Ministry of Health has handled mental health policy, and the reasons why system reform has remained elusive.

The first mental health law, passed in 1950, gave origin to the Mental Health Council, an advisory group of experts, and led to the creation of the first mental health department within the Ministry of Health in 1953, the Department of Mental Hygiene, which held authority over matters related to the management of mental health problems. In 1964, the Mental Health Council, led by Honorio Delgado, presented the first National Mental Health Plan, but its proposals were not taken into account by the

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<sup>8</sup> Some primary healthcare establishments do have psychologists, but they are usually involved in a one-year pre-professional programme and leave after completing it.

Ministry of Health. The status of the Department of Mental Hygiene had been lowered in 1961, when it turned into a division, and became further marginalised in 1970 as an advisory unit. Moreover, the Mental Health Council seems to have disappeared after the early 1960s. Mariátegui (1990, p. 131) blamed this setback of mental health policy on the Ministry of Health officials at the time, who he claimed were mediocre and improvised. According to him, they were not willing to implement mental health policy because they did not consider it a public health matter.

In the 1970s, the only project undertaken was a draft for a National Mental Health Plan written by Rotondo and Mariátegui, who were supported by the Ministry's mental health adviser. Once again it did not see the light of day. Mariátegui (1988, pp. 24-25) regretted not having published the draft, which was only disseminated in a limited and surreptitious manner.

In 1981, Rotondo and Mariátegui became involved in a special committee, convened by the Ministry, which was to make propositions regarding mental health policy. This time, their efforts were more fruitful. Following their advice, the Ministry created the Department of Mental Health within its organisational structure, an entity that would be in charge of national mental health governance. Its main endeavour was the elaboration of a normative document that defined the terms under which mental health services should be decentralised—that is, how treatment should look like in general hospitals and primary healthcare centres around the country. The Ministry made this an official document in 1984.

the National Institute of Mental Health—Instituto Noguchi—was donated by the Japan International Cooperation Agency in the early 1980s and Mariátegui was named its director. As an institute, its main role was to provide the expertise the Ministry needed for mental health policy planning. Research was supposed to be its core element, underpinning every area of work developed by Noguchi (for example, training of personnel, therapeutic models, or community mental health strategies) (Mariátegui, 1988, p. 42). Furthermore, the epidemiological tradition of the institution started early on with a study of a nearby urban district, using diagnostic criteria from the newly elaborated third version of the American diagnostic classification (DSM-III) and placing little emphasis on the socioeconomic determinants of mental health problems, showing a different style from the one exhibited by the social epidemiology of the 1960s.

1985, a newly elected government decided to reorganise the Ministry and deactivate the Department of Mental Health. Mental health decision-making was transferred to the psychiatric hospitals, which formed a governing trio with Noguchi holding the lead position. This association between hospitals did not work as planned, however, and in practice they remained isolated. This move was a setback in policy because the normative guidelines that had been developed by the Department of Mental Health in previous years were forgotten.

Mariátegui (1988, p. 43) favoured the decision of granting Noguchi more decision-making power, arguing it was better to operate from an institution that was in direct contact with reality than from an office in the central entity. But Noguchi, originally thought of as a research centre, was not able to comply with its normative role. In reality, rather than transferring the role of policy implementation, it was pushed into the background. Noguchi was not in a position to get things done because, as Mariátegui asserts (1988, 251-264), communication with the Ministry was not optimal and they did not achieve real influence at a national level.

This failure to cope with the new role was used as an argument for replacing Mariátegui as director of the hospital in 1987. He was replaced by an outsider, someone from another psychiatric hospital, a move that was not well received by the Noguchi crowd. The decision was also critiqued because Mariátegui was an appreciated figure of Peruvian psychiatry. It was the last the public sector was going to see of him.

It is common knowledge among psychiatrists that, despite the official motives displayed, the real reason for firing Mariátegui was to get someone from the government's party in charge of Noguchi. This is a party known for carrying out these types of actions when in power. It is interesting insofar as it represents a rare instance of direct government intervention upon the psychiatric hospital, a figure otherwise on the fringes of national politics. This situation led Mariátegui to publish a book where he explicitly acknowledges that the new government had been issuing false claims against him and the institution (1988, p. 237). In a veiled reference to these political cravings, he critically claimed the institute was not a stronghold, that it was a creative effort that demanded the best from its leaders, who should aspire to serve the institution rather than being served by it (1988, p. 144).

In the 1985-1990 period, Noguchi's leadership managed to produce two policy documents that were passed by the Ministry. New to this process was the formation of committees that gathered multiple actors—hospitals, the Ministry of Health, universities, the National Science and Technology Council, professional associations, and PAHO consultants—, whereas in past ventures consultancy was carried out by small groups of psychiatrists. In 1986, the first of these committees wrote the Guidelines for Mental Health Policy and submitted them to the Ministry, where they were officialised after two years. In addition to promoting the decentralisation of mental health services, the guidelines addressed the elaboration of a national mental health plan and the reestablishment of a department of mental health within the Ministry. The Ministry complied with the first suggestion and the National Mental Health Plan was approved in 1990.

In 1990, a new government was elected and its authorities decided to change the course of mental health policy. They dissolved the formal association that had been created between the three psychiatric hospitals and, following the recently published guidelines, created a Department of Mental Health within the Ministry in 1991. This central entity took over the mental health governance role that had been laid upon Instituto Noguchi in past years. The hospital's director at the time enthusiastically announced in the institution's journal that they were returning to their original research and advisory position (Castro, 1990). Under the leadership of a psychiatrist, the Department of Mental Health gathered a new committee of experts in order to elaborate the National Programme of Mental Health in Primary Healthcare, which was supposed to push the national plan into action. The document was written but failure ensued at a political level. The Ministry backed up and, once again, decided to dissolve the Department of Mental Health, which had not been assigned personnel or a budget.

In the 1990s, Peruvian state politics changed. As a response to the great economic crisis that the country had endured in the past decade, the new president applied a structural adjustment programme, pushed by the International Monetary Fund and the World Bank, which made the government reduce its involvement in the public sector. Whereas in the 1980s Noguchi suffered the government's intrusion, psychiatric institutions now faced the opposite scenario: they were given absolute independence. They could choose their own hospital authorities and had to figure out how to cope with a sector in crisis and with diminished human and economic resources. The tendency

that arose, supported by the Ministry, was to establish paid services that covered hospital expenses without the need for external funding.

In addition to the management of hospitals, the Ministry delegated mental health governance. In the second half of 1993, instead of establishing a new direction, a mental health programme was created and the power to manage it handed over to Noguchi. The hospital's director, who welcomed this new development (Macher, 1994), was head of the programme and a team from the Department of Community Mental Health was in charge of running it. The programme was the first of its kind to be put into practice in the country and it lasted until the end of the decade. The core strategy was to create the position of mental health manager in every region of the country and make them develop operational plans, with Noguchi experts acting as advisers. In addition to this, the team also developed a number of projects in different parts of the country. Activities had an intersectoral and participative approach and were related to mental health education, violence and substance abuse prevention, and programmes for victims of political violence and natural disasters. A primary care task-sharing programme was also set up, in which doctors and nurses were taught how to detect and treat mental health problems such as depression, psychosis, and violence (Sub-Programa Nacional de Salud Mental, 1996).

However, as I gathered from verbal accounts and documents, the National Mental Health Programme did not receive the support required for it to operate at such a large scale. With insufficient funds, rather than a uniform and coherent national programme, it could only hope to be a fragmented set of activities scattered over the country's territory, with varying levels of development and little capacity for supervision and programme evaluation.

In 2001, after Fujimori's decade-long presidency, the national programme was cancelled and mental health became marginalised within the Ministry until the 2003-2006 period, when two successive health ministers decided to revert this. The first one created the Mental Health National Sanitary Strategy. A psychiatrist was appointed head of this programme and was also named director of the Department of Health Promotion by the following health minister. This was significant because being in charge of a department within the Ministry would give him and the mental health programme more ascendancy.

An advisory committee was set up for the elaboration of the strategy. It included psychiatric figures, two NGO psychologists, a medical anthropologist, and the leader of a mental health service user group. National workshops were convened in order to identify local problems and give shape to regional plans. The general plan for the strategy was published by the Ministry in 2006. Concurrently, a Department of Mental Health was created once again.

In this same period of time, two important mental health policy documents were created and officialised by the Ministry. The task was carried out by the National Mental Health Committee, an entity within the Ministry's structure that gathers experts and stakeholders in order to decide on policy matters. Mental health policy guidelines were issued in 2004 and this led to the publication of a National Mental Health Plan in 2006, replacing the one that had been established in 1991. In keeping with a broad definition of mental health, beyond the realm of the health sector, the committee went so far as to propose responsibilities for other national ministries, although these did not successfully materialise.

Concomitant to this streak of successful mental health policy-making were three different events or tendencies that called attention to the country's mental health situation. The first was a series of studies (Ministerio de Salud, 2006; Defensoría del Pueblo, 2005; Mental Disability Rights International and Asociación Pro Derechos Humanos, 2004) that reported deficiencies in psychiatric services and called for the protection of patient rights. The second one was the final report of the Truth and Reconciliation Commission that exposed the dire mental health consequences of the armed conflict between the Maoist guerrilla group Shining Path and the state in the Southern Peruvian Andes. In response to the report, the government issued a plan of reparations that included sending mental health teams from Lima's psychiatric hospitals to the affected areas once a month in order to provide treatment. Finally, a considerable body of epidemiological data was produced. The Ministry of Health published a burden of disease study that placed neuropsychiatric disorders as the first cause of healthy life years lost in the country (Ministerio de Salud, 2004) and Noguchi started its project of mapping the high prevalence rates of mental health problems through the implementation of epidemiological studies in multiple regions of the country.

In the 2006-2011 period, a new government shifted its health policy priorities and did not go ahead with what was programmed. The Department of Mental Health was



relegated and they kept a psychiatrist as head of the Mental Health National Sanitary Strategy, although the programme was not supported with personnel or funding (Castro, 2010). This was the second time in government of Alan García, the same president whose government had directly interfered with Instituto Noguchi in the 1985-1990 period, although this time the mental health sphere was not on his radar.

In the next presidential term, 2011-2016, the first health minister decided to take up mental health policy-making again and enable the Department of Mental Health by designating a psychiatrist as its director (Organización Panamericana de la Salud, 2012, p. 10). However, many psychiatrists that I talked with complained that this entity had scarce resources and was not able to establish ambitious goals. Additionally, they claimed, this newly created space had not gained much leverage in the decision-making process because it was subordinated to a larger area that did not have mental health as its top priority.

Nevertheless, the Ministry did take some measures towards mental health services reform while I was in the field. The national health insurance plan expanded its mental health coverage (Andina Agencia Peruana de Noticias, 2013), and norms for the implementation of mental health in hospitals and primary care centres were passed. Noguchi's leadership also began to push for a services reform programme in Lima and the psychiatrist who was in charge of the Department of Mental Health at the Ministry was replaced by Noguchi's director of community mental health. In January 2015, a statement by the Ministry issued in the press announced that 150 primary healthcare doctors were going to be trained and 30 psychiatrists deployed to primary healthcare centres across the capital (El Comercio, 2015).

### Mental Health Governance: Who is in charge?

As we can see in this historical review, the leadership role in national mental health policy has been volatile. Sometimes non-existent, sometimes situated in a department within the Ministry of Health, and sometimes assigned to Instituto Noguchi. Most of the people and sources that I consulted argue in favour of the Ministry, although I met a few Noguchi psychiatrists that like the idea of being in charge, including its first director Mariátegui.

In keeping with the desire to integrate mental health into the general health sphere, it would seem convenient to maintain decision-making within the Ministry, rather than separating it from the regular health authority structure. The presence of mental health experts within the Ministry allows them to be more influential in the policy decision-making process. In addition to this, the long-established national presence of the Ministry and its position of authority ensure a higher level of acceptance by other institutions and societal organisations. Rather than discarding a central mental health office, it could be assigned more resources and its coordination with the psychiatric hospitals reinforced.

If mental health policy decision-making should be maintained within the Ministry, what is the role of the national institute of mental health? In the case of Noguchi, this has been a central theme throughout its history. It started operating as a regular health service in 1980 and it was transformed into a national institute two years later. Despite having the physical and organisational form of a hospital, Noguchi established research as its top priority and, to this day, it promotes this activity among its members and allocates less time for consultations than a regular hospital. However, it was not able to entirely evade the hospital role. Notwithstanding its initial intentions, it ended up operating as a specialised hospital for all of the northern part of Lima—composed of approximately two million inhabitants —, where its services generated great demand. A Noguchi psychiatrist who I interviewed defined this situation in the following terms: the institution wants to be an institute but, in the face of demand pressure, is compelled to be a hospital.

Service duties overshadowed Noguchi's research mandate as a consequence. In Peru, a couple of informants told me, national health institutes are more hospitals than institutes, or hospitals with only a slight interest in research. Prioritising research is seen as a luxury that cannot be afforded in a context of poverty and lack of services. According to a past Noguchi director, most psychiatrists are immersed in treatment activities without finding the time for doing research (Perales 1988, 86). Under these circumstances, research is a sporadic and individualistic venture that some psychiatrists develop in their free time. The institution's input into public policy has also

been sporadic and individualistic, usually occurring when the Ministry of Health summons experts to work on specific tasks.<sup>9</sup>

Since the onset of the new century, however, a new take on the institute's mission has been put forward. It should not limit itself to having an instrumental role, its proponents appear to say, but rather seek to develop a strong voice within the policy-making sphere and advocate for the implementation of decentralised national mental health services. Noguchi had to take the initiative because, as the two key figures of this new approach told me, if they did not, then no one would. The first component of this strategy was the nationwide epidemiological studies that, since the early 2000s, were developed by the hospital's Research Department. They were meant to mobilise authorities by “denouncing” the high prevalence of psychiatric disorders in the country. The other element was Project Apurímac, the large services reorientation project applied in an Andean region of the country by the Division of Collective Health<sup>10</sup>, focused mainly on the training of primary healthcare personnel and meant to set an example of mental health services reform for the Ministry of Health and regional governments. These endeavours had so far been successful in securing funds from the Ministry. In the case of regional governments, some of them—not the majority—became interested in replicating similar programmes in their own jurisdictions.

This new role proposed for the National Institute of Mental Health is one of indirect governance. Instead of assuming the role of decision-makers, they were aiming to promote a public policy agenda from their subsidiary position as mental health consultants. They replaced the previous scheme of providing individual expertise to the Ministry of Health with the collective planning of an institutional agenda. The epidemiological project, for instance, was brought about by gathering the research funds of the institute's different departments into a single project under the leadership of the Research Department.

## The Politics of Unachieved Reform

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<sup>9</sup> I should exclude Noguchi's community mental health area from this analysis since it has been more inclined to develop a research agenda of its own and influence public policy, as I will examine in another chapter.

<sup>10</sup> This was the new name of what was formerly called the Department of Community Mental Health at Noguchi.

As I have seen, efforts to decentralise mental health services in the country have existed for some time now, an agenda that has been reinforced by international health organisations since the 1980s and 1990s. In the following lines I will analyse why these attempts have failed repeatedly, leaving the system largely unchanged.

Mental health holds a marginal position in Peru within medicine, political structures, and society in general. Within the Ministry of Health, mental health has not been a priority, receiving only between one and two percent of national healthcare funding in the last decade (World Health Organization, 2005, p. 371). Policymakers have remained focused on physical health, based on the traditional epidemiological approach that grants priority to the problems that have most impact on mortality rates. Regional governments are another political space where mental health has been overlooked. These authorities were recently granted a high level of autonomy in health matters, as part of a general decentralisation process started by the government in 2002 (Granados, 2015), but many of them have not been interested in implementing mental health services.

In conversations and texts written by senior psychiatrists, I found a common trope used when evaluating the history of Peruvian mental health policy. Mariátegui, quoting a famous Peruvian historian, wrote that Peru is a country of lost opportunities (1988, p. 23); another Noguchi director referred to the long path of projects subsumed in purposes and purposes reduced to good intentions (Castro, 2010, p. 35); finally, a Larco Herrera psychiatrist, which I interviewed in a consultation office of the hospital, told me about how Rotondo—who had been her mentor—exhibited a resigned attitude when developing policy programmes for the Ministry of Health. "I am doing another project yet again", he used to tell her. She thought there will always be projects, but political will is lacking.

These accounts reveal a story of reiterated failure. As I have reviewed, national mental health plans have usually not been approved or, when approved, have not been given the resources needed for implementation. Furthermore, mental health has remained ostracised in Congress as well. There is no mental health legislation whatsoever. Since 2005, a group of congressmen has been trying to pass a comprehensive mental health law to no avail.

The political dynamics of the public sector were often brought up by my informants when accounting for the little progress made in the field of mental health policy. As in

other tiers of the health system or the public sector in general, health ministers tend not to last too long in their jobs. Alberto Perales, an ex-director of Instituto Noguchi, told me in his private office that "authorities change too fast. A minister does not last, on average, more than a year. One starts getting close and convincing him, but then he is changed. And when he is changed, everyone else is changed as well". This would not be such a big a problem if there was continuity in the work done by each authority that reaches a certain post. But, Perales continued, "each authority generates new projects, changing and limiting what has been done before them, without evaluating if it has been positive or if it needed to be changed in any way".

Thus, mental health policy has been cut short over and over again, without being able to make much progress. It has had to start over again every time a new Minister decided to change what was previously planned. My informants often used cyclical metaphors such as "going in circles" when referring to the non-cumulative temporality embedded in this type of politics. The multiple shifts made regarding the Ministry's Department of Mental Health—at times enabled, at times dismantled—over the years are a clear example of this. Perales criticised the whimsical manner in which the Ministry has handled this matter:

It has changed a lot. Ridiculous things have been done, things that can only happen in Peru. When Noguchi was thriving, the Ministry thought it was a good idea to put it in charge of the mental health sector. And it did that. But it also changed the name of the other mental hospitals, making them institutes as well (laughter). It was the only country with three mental health institutes. It was amusing.

The marginalised position of mental health within the Ministry of Health and the political instability of the public sector are important factors when trying to explain this scenario of unachieved reform. But they are probably not the only ones. Psychiatry as a profession has the lead role in the mental health arena. It is the one in charge of mental health services and the National Institute of Mental Health, and the one that has engaged in policy matters in the past. However, the number of psychiatrists interested in public policy implementation and related tasks is quite small. For the most part, psychiatrists in Peru are focused mainly on their work as practitioners at psychiatric hospitals or private practices. And this is also the case at Noguchi, which works more as a hospital than an institute. Noguchi's current Research Director explained to me in

his office the considerable difficulties found in the process of trying to convert psychiatrists into public health researchers:

Imagine a person that has been dedicated to seeing patients for fifteen years and has maybe done some small studies here and there. All of a sudden we tell him: "You know what? Now you have to find bigger, far-reaching, answers for the population." That transformation is hard to accomplish and we have gone through phases where you have to take a step back, you have to slow down. And that happens due to persons who think that it is not worth it. But if we are going to be in charge of this, then we have to make long-term bets.

Thus, the average psychiatrist does not embark on research projects, public health programmes, political advocacy, or any type of activity related to developing a mental health policy agenda. While I was in the field there was a small group trying to do this at Noguchi, but they had little to work with in terms of willing psychiatrists. Perhaps a way out of this problem would be to create novel educational spaces where psychiatric residents could become interested in new ways of regarding their professional role. Two obvious sites—mandatory stops for psychiatrists—would be medical schools and psychiatric hospitals. Spaces where knowledge and practices can be redefined and new ideologies carved out.

There is also considerable resistance to mental health in general health services. Doctors tend to think that psychiatrists and people with mental health problems belong in separate establishments. When I was interviewing a Noguchi psychiatrist in his private office at a high-end district of Lima, he expressed frustration towards this issue by recalling a research experience of his in a hospital from Cuzco:

Hospital budgets should prioritise mental health. In many regional hospitals, they prefer to sign a surgeon, a gynecologist, or a pediatrician when they have money. They say that these professionals are needed more. For a long time, many hospitals from the regions did not have psychiatrists because doctors had generated that kind of policy within the hospitals. The hospitals' cuerpos médicos opposed signing psychiatrists and preferred other specialties. In Cuzco, when we went for research purposes, we arrived at the Hospital Regional de Cuzco and they did not have a psychiatrist. A psychologist was in charge of the Programa de Salud Mental. They said they had decided not to sign a psychiatrist because a gynecologist or a surgeon were more important. After that, when we went to the epidemiology office, we saw that the main cause of registered deaths in the Hospital Regional de Cuzco was violent deaths. Violence cannot be tackled by gynecology, pediatrics, or surgery. Behind violence you will find alcohol

consumption or other mental problems. But they did not understand that. Thus, this is a problem of perception and, also, of dialogue between psychiatrists and colleagues from other specialties.

Although the law requires every hospital to have an established amount of psychiatric beds, doctors carry prejudices that are hard to get past. As another psychiatrist told me in an interview at a consultation room in the emergency area of Noguchi, mental health is seen as esoteric—a realm where psychiatrists treat schizophrenia or severe depression, leaving out the milder side of the spectrum and the emotional dimension of other medical conditions. This is partly rooted in medical education, where the curricula tends to focus more on psychopathology and less on medical psychology. Mental health instruction for young medical students consists in looking at schizophrenia in psychiatric hospitals rather than the more prevalent maladies that are found in general hospitals or primary healthcare centres. In this sense, curriculum changes should be advocated in order to start changing entrenched medical views of mental health and psychiatry.

### An Alternative Avenue towards Reform

The Grupo Impulsor de La Reforma (GIR)—group that promotes reform—was a small group of people interested in mental health that had been established in 2009, four years prior to my fieldwork. As the name of the group suggests, their goal was to advocate mental health reform. They had not been successful, however, in becoming a visible voice in the public domain or even in the psychiatric sphere, where only a few specialists interested in the topic knew about them. I heard about them early on in my study and e-mailed the PAHO representative in charge of convening the group, who answered that she was going to ask the other members if I could join them in their meetings. I received an invitation five months later, in the first days of 2013, for a meeting at the PAHO headquarters in Lima. I went to three of these monthly meetings, two at the PAHO locale and one held at Hospital Valdezán. The first two consisted in planning the group's operations for 2013 and the third one was dedicated to evaluating their past work and strengthening their proposal.

This PAHO initiative had the merit of gathering a diverse set of actors and initiating a potential conversation between them. The need to join efforts and complement

different perspectives was apparent, as the following group statement taken from a meeting summary suggests: "There are two routes: civil society and the state. It is necessary to congregate different actors. An example of this is the mental health law: there is one psychosocial proposal and one health services perspective. GIR used to congregate both sides."

At the community mental health departments of Hospital Valdizán and Instituto Noguchi, I witnessed some conflictive relations between NGO and hospital personnel based on their competing mental health perspectives. For example, a project manager from a human rights NGO that had a project with a service user group from Noguchi disapproved of the "medical approach" that community mental health workers had, and argued that they promoted relations of dependency rather than empowering individuals with chronic disorders.

Furthermore, a psychiatrist from Noguchi's Division of Collective Health raised her voice of concern about how NGOs operate:

NGOs work according to their own guidelines and in an isolated manner. They should align themselves with mental health public policy, led by the institute. They should approach us and say: "We are doing rehabilitation workshops, we are strengthening community participation". They don't do that. We have seen that in Apurímac also. There are some NGOs that have a budget and develop isolated actions. They don't approach us or align with our actions, even though they know we are a governing authority.

This account echoes critical social scientists who have pointed out that NGOs do not work hand in hand with state institutions. Some authors point out that NGOs are chiefly accountable to their donors, not to the state or the communities they work in. Thus, their behaviour will ultimately depend on the interests of their benefactors (Janes, 2004, p. 464). Nichter (2008, p. 138) adds that this situation often leads to the "depoliticising of development and the representation of poverty and disease as technical problems that NGOs can fix, rather than larger structural problems that call for more systemic social changes". NGOs are a varied set of entities, however. This underlined tendency does not rule out the existence of those organisations that are interested in broader structural change and public policy advocacy, as shown by the presence of a few of them at GIR meetings. Namely, they were a feminist group, an NGO of psychologists who treat people affected by political violence, and a psychiatric clinic managed by an



international Catholic organisation.

GIR's main goal was to advocate more mental health public investment for the implementation of services through the organisation of meetings, forums, campaigns, and workshops directed at Ministry decision-makers, other political actors, and the media. They were helped by communication experts in the elaboration of this strategy. In the past, GIR had successfully advocated the creation of the Ministry of Health's Department of Mental Health. The group had also published a document where they described and evaluated the progress of services reform pilot projects like the ones of Hospital Valdizán and Instituto Noguchi (Organización Panamericana de la Salud, 2012). Furthermore, short presentations were given in the monthly meetings by different members of the group in order to reinforce the body of knowledge that served as support for their actions.

The attendance to the GIR meetings had changed dramatically a year before I gained access to them, after the Department of Mental Health was created in the Ministry. The group started with thirty members and had reached fifty, including psychiatrists from the hospitals. In the time of my participation, the PAHO representative convoked them and settled that two of the monthly meetings were going to be held in the hospitals. But it became clear they were no longer participating; they did not show up at the meetings and Noguchi was cancelled as a venue. This situation led the group to plan a meeting that was fully dedicated to rethinking their mission in May 2013.

The meeting was programmed at the PAHO headquarters from 9am to 2pm, but I arrived at 10.30am because I had an interview with a Noguchi psychiatrist that morning. I decided not to cancel it because he had a busy schedule and was hard to catch. The GIR meeting was held in a small conference room with a typical rectangular table in the middle. The last gathering in the same venue, four months ago, had been held in a bigger conference room that had a u-shaped table in it. I do not know if it was the smaller setting or the longer duration, but this meeting was much more jocular than past ones. The number of attendees in each of these meetings was between 12 and 15 people. The attending members—six psychologists, five psychiatrists, a lawyer, an epidemiologist, a social worker, a service user group activist, a media expert, a disability rights consultant, and a community project manager—came from different institutional backgrounds such as universities, the Ministry of Health, the Municipality of

Lima, other government institutions related to health research and human rights, NGOs, and private practice. Along with the decline in participation from the public hospital psychiatrists, another transformation in the composition of the group had ensued: the presence of more civil society members.

The table was full of dishes with mini-sandwiches and cups of coffee. As I was sitting down, the PAHO convener said that GIR had to be “amended”. That they had lacked structure. They had the right ideas but had not been able to implement them. A psychologist then argued that the public hospital psychiatrists needed to be included in their advocacy efforts. GIR should organise events where they can be invited to give talks, she proposed. Another psychologist, from a different university, agreed. The presence of hospital psychiatrists would enhance their advocacy pretensions due to their position of influence within the mental health sphere.

Some hospital psychiatrists complained that the PAHO is too dogmatic. “They do not debate. They have a transnational policy that is not adequate for this country,” one of them told me. They definitely had the strongest voice in GIR meetings, where most of the talk was done by the PAHO representative, while other members offered sporadic suggestions and support. While some participants offered, at times, critical comments against the psychiatric establishment—for example, the psychiatrist who was Mental Health Director at the Ministry of Health said that Peruvian psychiatry lacked “the community approach”—the PAHO official was usually neutral in her appreciations, focusing more on eliciting her institution’s official policies. At one moment, for instance, she recalled the terms of the Caracas Declaration and “the PAHO’s mental health treatment model” and, on another occasion, she brought up a PAHO document about advocacy that she had e-mailed to us, adding that “advocacy is more than handing out brochures and making campaigns, it is about achieving change.” She also frequently established the limits of discussion by turning down proposals made by others or stating the group’s mission. In one of these moments, she clarified that GIR’s aim was to advocate for the “reorientation of services”, not to push a more comprehensive model of reform. An NGO project manager replied that, while acknowledging the focalised goal that was being established, her institution believed in wider reform.

The PAHO convener was aware, however, that they had become known as “the PAHO group” and that this, in her words, “generated misunderstandings”. This is why she was not going to be part of GIR’s new organisational apparatus, which the group

hoped would facilitate the implementation of their plans. She announced that GIR's central coordination committee was going to be formed by a psychiatrist, someone working in the government, and a civil society representative. For the first position, she had thought of a respected old-timer who had some clout in the Ministry of Health. This psychiatrist and Mariátegui were the first to develop a community psychiatry service in Peru, the PAHO official told us; you can still visit the place and find a nurse and the clinical records from those years. One of the psychologists objected: it would be better, from a promotional point of view, if someone with a promising career took the position. She proposed three possible candidates, two Noguchi psychiatrists and an epidemiologist who worked at the Ministry of Health. The PAHO official observed, however, that Noguchi's Project Apurímac director was "playing his own game"—focused in following a separate road towards mental health reform—and did not have time for GIR, while the epidemiologist had a current dispute with hospital psychiatrists.<sup>11</sup> In addition to the senior psychiatrist mentioned before, the PAHO convener announced a Ministry of Health doctor and a private practice psychologist—both present at the meeting—as the other two members of the central coordination committee.

Another logistical subject discussed at the meeting was how to fund the group's activities. The Ministry of Health doctor introduced the issue: "We haven't done much in four years. We need funds if we want to do more." One of the psychologists suggested that the government could provide funds, but the PAHO official rejected this bluntly. The proposal of generating their own funds through the organisation of "academic events", made by the national Mental Health Director, was better received. Then came another proposition that was rejected. A lawyer from the Defensoría del Pueblo (national ombudsman's office) commented that they could officialise GIR by registering it in the country's public records. Again, the PAHO official expressed her opposition. This time she was backed up by the NGO project manager, who told a story about another health advocacy group that started out with volunteers, subsequently obtained funding for a secretary, and finally turned into an official NGO. This trajectory, she claimed, had devitalised the organisation's work. The PAHO official, in agreement, sentenced that "ONG mata movimiento" (literally meaning "NGO kills movement"). Finally, the

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<sup>11</sup> As I develop further in my conclusions, this epidemiologist had been in charge of conducting the World Mental Health Survey in Peru and had criticised Noguchi's epidemiological studies for showing excessive mental illness lifetime prevalence figures.

psychologist who had made the initial proposal concluded they could all try to use their respective institutional positions to apply for funding opportunities that would benefit GIR.

The last topic of discussion was brought up, again, by the Ministry of Health doctor, who offered another precautionary remark: “We are rushing into planning. We should avoid ‘wild activism’. We need to make a diagnosis of the four years of GIR.” The PAHO convener replied that this diagnosis would have to be made by the people who have been a part of GIR, most of whom had stopped going to the meetings. In view of this, the private practice psychologist, who was now a member of the central committee, volunteered to create an online survey that could be sent to past group members and everyone appreciated the offer.

The NGO project manager had been in charge of transcribing the considerations and agreements discussed during the meeting. At the end of the session she was typing up the attendance list on her laptop when the PAHO official said we should all just write down our names, but not our institutions. I did not know what to make of this at the moment, but it made sense afterwards, when I interviewed Noguchi's Project Apurímac director in his office. Upon questioning, he told me that he stopped attending GIR meetings because it was a civil society group and he was a state employee. Thus, if we just put down our names, we are participating as regular citizens, not as members of a specific institution. This would assumingly eliminate the obstacle articulated by the Noguchi psychiatrist.

When we were standing up from our seats, the Ministry of Health doctor disclosed that he had heard someone refer to the group as “the crazy people from GIR”. Someone retorted that he was hearing voices and everybody laughed. The PAHO convener asked who had said that and both the doctor and the national Mental Health Director revealed the identity of the guilty party, who worked at the Ministry of Health. “They are afraid of us”, the PAHO official settled. “There’s barking Sancho<sup>12</sup>,” the Mental Health Director uttered reassuringly.

As I have seen, the two psychiatric hospitals that had mental health reform projects—Valdizán and Noguchi—distanced themselves from this multidisciplinary

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<sup>12</sup> The expression “There’s barking Sancho, it shows that we are riding”—a reference to Cervantes’ Don Quixote—is commonly used in Peru as a way of saying that negative criticism is a sign that you are doing well.

group. Noguchi decided to bet it all on its own advocacy efforts, which eventually turned out to be successful since the Director of Project Apurímac became the Ministry's head of mental health. However, this denotes a focus on a specific aim—to convince health authorities about the importance of mental health services reform—that could become jeopardised in the near future by the country's unstable public sector dynamics. Thus, engaging in a wider advocacy and communications strategy that addresses society as a whole seems like a sensible add-on to the reform agenda, and one that would be most likely achievable through the collaboration of psychiatry and the other interested parties represented at GIR.

## Listening to Other Voices

Until now I have reviewed and analysed the efforts made towards reform within the Ministry of Health, the psychiatric profession and a PAHO-sponsored advocacy group. I have not, however, seen what mental health reform means specifically. I will start examining how prescriptions for an improved mental health system have evolved over the decades.

A first model of reform, represented in Mariátegui's writings when he was Director of Noguchi in the 1980s, promoted the implementation of specialised mental health services in each tier of the health system. In addition to the psychiatric hospitals, psychiatric units in general hospitals, community mental health centres, and community psychiatry programmes were to be created (Mariátegui, 1988, p. 71).

In line with the PAHO's Caracas Declaration of 1990, the next Director of Noguchi proposed the inclusion of a mental health component in the primary healthcare strategy and the development of intersectoral mental health planning (Flores and García Trovato, 1988, p. 18). As the 1990 National Mental Health Plan shows, treatment was only one part of a model composed also of preventive, promotional, and rehabilitative activities. Furthermore, Mariátegui's successor believed in developing a culturally relevant approach by rescuing traditional knowledge and searching for new treatment models adapted to the particular characteristics of Peru's population (García Trovato, 1987, p. 8).

Despite these ambitious models projected by psychiatric leaders in the 1980s, the only aspect that was applied by the 1990s National Mental Health Programme—in terms of system reform—was training primary healthcare personnel in the detection and treatment of mental health problems, a strategy that did not prove to be effective. In the 2000s, moreover, another set of policy documents declared the need for a comprehensive mental health reform, similar to what was proposed by the 1990 national plan. Intersectoral mental health planning, user participation and strategies for the development of mental health human resources—an element I have not found in other plans or discussions on the topic—were to be included in the implementation of reform (Bustamante, 2009, p. 190).

Finally, GIR's vision of how the mental health system should look like was focused on the development of a diverse set of mental health services: treatment in primary healthcare establishments and general hospitals, community-based rehabilitation, residential facilities, community mental health centres, day care services, and substance abuse specialised treatment.

As I have reviewed, the actual implementation of mental health policy has made more progress than in the 1990s, but there is a tendency towards narrowing down the comprehensive reform scheme put forward by policy documents to the detection and treatment of mental health problems in already existing public health services (primary care centres and hospitals). In the face of political indifference and meagre resources, reducing the treatment gap through this basic reform component has been established as a key priority. This became patent in a GIR meeting when the PAHO official told another group member that "the objective is to reorient services, not to do an exhaustive reform covering more than that."

Another aspect that I found to be neglected in mental health reform discourse was thinking about the appropriateness of the current psychiatric treatment paradigm, a topic I will be developing throughout this thesis. At GIR meetings, interest laid in strategies for advocating services reform, not in discussing the adequacy of psychiatric treatment. The short talks that took place at the beginning of each meeting were all psychiatric or epidemiological in nature. In this way, alternative perspectives hinted by psychiatrists and policy documents from the 1980s and 2000s seem to have faded away. These other "voices" that talked about recognising cultural patterns, designing

new and more efficacious models of treatment, and adapting practice to local settings are being overshadowed by a monotonous psychiatric model taken at face value.

These critical remarks I am making resonate with the observations that social scientists and critical psychiatrists have made about the Global Mental Health movement. They have accused it of narrowly focusing on promoting a medicalised model of mental health services that loses sight of social and cultural context (Kirmayer and Pedersen, 2014, p. 765; Summerfield, 2014, p. 408), arguing that psychiatry and the global mental health agenda should take note of the specificity of local worlds, which include idiosyncratic help-seeking pathways (Khoury et al., 2012; Cooper, 2016; Orr, 2012), complex treatment assemblages (Ecks, 2014; Bartlett, Garriott and Raikhel, 2014; Sax, 2014; Sood, 2016; Quack, 2012), and variations in the effects and efficacy of psychopharmaceuticals (Lee, 1993; Lin, Poland and Lesser, 1986; Ninneman, 2012).

Jain and Jadhav (2009, p. 78) state the necessity in India for “social and political space that would facilitate and encourage the development of multiple models of mental health care.” In the following chapters I intend to argue that, if it wants to successfully fill the treatment gap, Peruvian psychiatry should open up to interdisciplinary collaboration and facilitate the inclusion of diverse viewpoints that would make for a refined mental health reform agenda.

## Community Mental Health at Hospital Valdizán

### La Reforma

“All of the charts you see here are related to La Reforma. This is the room of La Reforma,” said Dr Navarro while pointing to the multiple papers that were glued to the surrounding walls. It was Friday afternoon and I was interviewing the hospital director in his office, a spacious room made of faux wood that looked elegant in comparison to the other offices I had seen within the compounds. I was given an appointment by his secretary after submitting a written interview request to the reception desk. We sat at a distance, facing each other in a large conference-style table. Formally dressed, white-haired, bearded and with glasses, Navarro maintained a solemn attitude during our meeting. I did not ask too many questions and he spoke at length about La Reforma.

Navarro is a psychiatrist with a prolific career who became the director of Hospital Valdizán in 2009. One of his main motivations for applying to this position was to put into effect La Reforma, which had as its main goal to restructure mental health services with a “community approach” in the area where the hospital is located (Navarro, 2011, p.13). He used the figure of the pyramid to illustrate this when I interviewed him:

Psychiatric hospitals are at the top of the pyramid. In Peru there are three. Almost 95% of the country’s mental health budget is spent by these three hospitals and there is nothing for the rest. At the second level, there are psychiatric services in general hospitals. This is poorly developed—some have them but not too many. And at the first level, where the primary health centres are, there is nothing. People have always talked about integral health, but it’s an incomplete health, without mental health. Therefore, the idea is to turn the pyramid upside down.

One of the main concerns was to take psychiatry and mental health services out of their ostracised position and integrate them with the general health system. This would reconfigure the layout of the demand for services. Decentralised mental health delivery operates as a “retaining ring” on the hospital’s periphery, alleviating excessive demand.



The referral system, based on levels of complexity, is activated and the psychiatric hospital converted into the endpoint of the mental health system, rather than its centre. There is no need for dismantling the mental institution, Navarro told me. It can be transformed into a smaller and highly specialised place that emphasises research activities and psychiatric training. Only psychiatric sub-specialties would be found within the psychiatric hospital, while regular psychiatry would be located in general hospitals.<sup>13</sup>

Navarro's plan started with a pilot project in Huaycán, a nearby urban community, which was implemented by the hospital's Department of Mental Health Promotion. The project did not get assigned a budget for itself, but was to use the limited one ordinarily allocated to the Department. A cooperation agreement was signed with the health authority of the area, called DISA Lima Este.<sup>14</sup> The project started operating in the micro-network area of Huaycán with the intention of progressively covering this entire DISA jurisdiction, comprised by eight districts and two million people. In order to promote the transformation of the mental health system, Navarro had to search for allies and advocate the creation of psychiatric units in general hospitals. While unsuccessful with the hospitals, he managed to engage the local municipality in the project and, among other things, they promised to open a residential care home for the homeless mentally ill.

On the one hand, the pilot project team has been implementing a mental health training programme for the primary health centres and general hospital of Huaycán. They have also trained lay mental health agents from the community and schoolteachers that are supposed to provide counselling and refer problems to the health centres. On the other hand, Huaycán's parish donated a community mental health centre where they offer consultations and manage a rehabilitation programme for people with chronic disorders. Their last line of action is related to preventive activities. Basing themselves on a PAHO model, they have developed a family intervention programme aimed at reducing risk behaviour related to substance abuse and sexual

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<sup>13</sup> Navarro was talking about maintaining the psychiatric hospital as an element of the health system, but this does not mean there should not be any dismantling. Policymakers should ask themselves how many specialised hospitals are needed in a city—Lima has three—and, given that these institutions concentrate most of the system's human resources, how many psychiatrists working within them today should be distributed to other kinds of services.

<sup>14</sup> Peru's public health system is geographically divided into DISA offices, which administrate networks and micro-networks of health establishments.

health. Finally, they carry out occasional educational activities in schools and other public spaces.

Based on the four months I spent with the team in charge of the project, I will depict their work mostly from the viewpoint of psychiatrists and discuss what effects the reform agenda had on how they deal with mental health problems in the community and the specific conditions and implications of the institutional branching out of psychiatry.

## The Department of Mental Health Promotion

The precursor of the Department of Mental Health Promotion was the Community Psychiatry Programme, a project started in 1982 as an extension of one of the hospitalisation wards (Bazán, 2004, p. 93). By 1996, “mental health” had replaced “psychiatry” in the name of the programme and in 2003 it was upgraded into a separate unit and the name changed to Department of Mental Health Promotion.

In 1999, given that the hospital’s catchment area was too big and the programme had a limited amount of staff, the decision was made to focalise it on a specific sub-district called Huaycán, with a population of more than 150,000 people. The area was described by the project team as one of the communities with more psychosocial problems in the eastern part of Lima (Chero, Figueroa and Luciano, 2003, p. 56). The Department’s work has ever since been based in this location and the project of La Reforma chose it as its area of initial intervention.

Ever since the 1950s, migrants from different regions of the country have established themselves in thousands of squatter settlements in Lima’s surroundings. Huaycán is a special case among these because it was established legally. Looking to alleviate the city’s housing problem, Lima’s municipality supported the initiative in 1984 and prioritised people’s participation in the creation of their own community (Comisión de la Verdad y Reconciliación, 2003, p. 419). This is why the real name of this subdistrict is Comunidad Urbana Autogestionaria de Huaycán (Huaycán Self-managed Urban Community), an unusually long name that expresses a sense of pride over this autonomous inclination. The first leaders had to deal by themselves with setting up things such as a security system, sanitation, and health and education services, resources that were incrementally obtained over the years, eventually with external help (Comisión de la Verdad y Reconciliación, 2003, pp. 422-424). Most of Huaycán’s first

dwellers were children of Andean migrants who lived in nearby districts as tenants and were looking for their own house (Comisión de la Verdad y Reconciliación, 2003, p. 421). Subsequently, during the 1980s and early 1990s, many arrived as a result of the process of displacement occurring in the Andean regions of the country due to the armed conflict between the Maoist guerrilla group Shining Path and the government (Comisión de la Verdad y Reconciliación, 2003, p. 418).

Huaycán's physiognomy and type of leadership changed throughout the years. Land takeovers have been pursued without much planning and the steep, inhospitable mountain slopes, which had not been taken as an option by the first residents, have since been occupied. This diversified the socioeconomic landscape of the community, since the newcomers' state of poverty contrasted with the stabilised position of the older inhabitants (Comisión de la Verdad y Reconciliación, 2003, p. 431-432). Furthermore, the initial conditions that enabled self-government and popular participation were hampered by the government and the Shining Path. Different governments have sought to grasp control over Huaycán's social assistance mechanisms in order to gain local influence, displacing local officials—quite aggressively, for example, in the case of Fujimori's regime—with the help of an emergent class of leaders that were willing to cede Huaycán's relative autonomy to outside concerns (Comisión de la Verdad y Reconciliación, 2003, p. 418). On the other hand, the Shining Path settled in Huaycán in the 1980s, as part of their plan to move from the Andes to the capital. Their insurgent message and totalitarian methods were, however, not well received by a community that was well organised and had a strong sense of autonomy (Comisión de la Verdad y Reconciliación, 2003, p. 418). What ensued was that the Shining Path assassinated Huaycán's most important leaders (Comisión de la Verdad y Reconciliación, 2003, p. 434), before being defeated by the government.

Meeting the project's team and joining their activities was the first step I took in my fieldwork. I knocked at the door of the Department of Mental Health Promotion, based on the first floor of a building located outside the hospitalisation area, at eight o'clock on a Monday morning. Luis, an early-career psychiatrist who was head of the unit, opened and gave me a warm greeting, inviting me to sit down with him at his computer desk. I shyly waved hello to the rest of the team members, who were minding their own business, some metres away, and sat with him. I briefly explained my research and he sketched out the pilot project in detail for me. The office was small. It had a big square

table at the centre, where most of the team worked. Luis and the secretary had separate computer desks set in opposite corners of the room. Some of the teammates were also stationed along the perimeter of the room at separate desks.

That same day I went with them for the first time to Huaycán. They used to go on Mondays, Wednesdays, and Fridays from 9am to 12 pm. During the rest of the week they stayed in the hospital for office work or other kinds of activities. A driver used to take them in a hospital van at 8.30 in the morning to the Centro de Salud Mental Familiar Comunitario Santísima Trinidad, which I will call the community centre from now on. It was a small establishment that had been donated by the local parish and served as their base of operations. It consisted of a waiting area, three consultation spaces, and two workrooms. Psychiatric interventions with patients were held by the attending practitioners in two of the offices and the other one was assigned for psychological consultations. These were utterly bare and impersonal spaces with no decoration or office gadgets, no personal possessions, and only a wooden table and plastic chairs as furniture. Fortunately, there was space for me in the van and I always tagged along in the thirty-minute ride that took us into the isolated gorge where Huaycán lies.



Figure 3. Me pretending to write something with a psychology intern in one of the community centre's consultation offices.

Luis and María, both of them young psychiatrists, were the newest members of the team. She had just completed her residency at Hospital Valdizán, while Luis had completed his at a psychiatric unit from a general hospital. In addition to them, there was a third psychiatrist called Martínez who was not part of the team, but the hospital had commissioned him to see patients at the community centre. Luz and Elizabeth—a nurse and a psychologist—were also young and had both arrived from other departments three years ago for the specific purpose of constituting the team of La Reforma. José, Milagros, and Patricia were a psychologist and two social assistants, respectively. They were older and had been there for a longer time. Milagros had been a founding member of the Department almost a decade ago. The group was completed by three psychology interns—Alberto, Antonio, and Carmen—, who were going to be there for a short period of time.

On one van ride to Huaycán, Luis and Martínez were talking about doctors who stay and work in other regions of the country. According to them, they accommodate to the new setting at the expense of a meaningful medical career. “He is a tiger<sup>15</sup> regarding what happens in his village, but he becomes out of touch in general,” Luis commented. Here, I think, he expressed an underlying value judgement that grants priority to the cosmopolitan medical world of knowledge production and circulation over the local realm of community health.

The number of psychiatrists involved in “community work” or public health programmes is scarce in Lima. There are few institutional spaces in which this sort of practice can be undertaken and psychiatric education remains tilted towards a paradigm of practice that privileges clinical abilities and the management of psychopharmaceuticals in the consultation office. When I asked Director Navarro what difficulties he had faced in implementing the pilot project, he singled out the “obsolete schemes” of psychiatrists as the biggest obstacle. They are hard to convince because they are used to practising psychiatry behind the walls of the mental hospital.

When María left the project team, leaving Luis as the only doctor in the Department, there were no other psychiatrists—or clinical psychologists, for that matter—who wanted to work there. Luis, with much resignation, broke the news that no one had

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<sup>15</sup> Term denoting knowledgeability.

applied for the job vacancy during one of the rides to Huaycán. “On paper, there are four psychiatrists in the Department,” he added, making us all burst into laughter.

It is paradoxical that psychiatrists do not want to work in this field but the Department has to be led by one. This is due to the dominant position psychiatry holds within the hospital, where it is the only profession allowed to have directorial posts. The first time I talked to him, the psychologist José complained about this situation, saying it was indicative of medicine’s hegemony. He compared it with the reality of Chilean mental health services, where other professions have greater ascendancy.

Luis had explicitly expressed his preference towards working within the hospital: “One becomes specialised to work in a hospital, not in the community,” he once told me. Elizabeth and María also preferred to do intramural clinical work. Elizabeth was a young neuropsychologist who worked as a diagnostician but was moved to the pilot project by Navarro basically because she was movable (older people with steady contracts could not be transferred against their will). One day at the office, after visiting her old department, she brought up the possibility of going back to work there, but Luis quickly said “over my dead body”. Luis and María, for their part, were both looking for a job after having finished their residencies. With his strong neurobiological orientation, Luis was an unlikely person to be leading the project. When we were getting to know each other in my first day on the van, Luis remembered he did not know what to do when he first arrived at the Department because he had no previous experience in this field.

Furthermore, the intern Alberto commented that psychologists are barely taught community mental health during their undergraduate education. He thought that students are too lazy for this kind of work and are more comfortable in the hospital. The hospital, certainly, can be a sort of “controlled environment” that is less problematic than the community. In the wards, patients are removed from their natural setting, their experiential layers of family, community, and physical environment stripped down. Psychiatrists are left to practice their craft without as many distractions. I will hope to portray some of the messiness and difficulties that complicate medical treatment in the community in the remainder of this chapter.

I will start by looking at the relationships between the different team members. In this context, psychiatrists, psychologists, social workers and nurses share the same office and collaborate in multiple activities. There is an ongoing face-to-face relationship and

no physical boundaries separating them, whereas ward psychiatrists barely interact with psychologists, for example, and have offices that are separated from the other professions. Would this configuration exacerbate tensions between the professions? Or would it hold potential for a collaborative and harmonious relationship? In summary, relations were good between Luis, the psychologists and the nurses, while the social workers and María—the other psychiatrist—had more distanced and conflictive relationships with the rest.

The Department had, most of the time, a light-hearted atmosphere. Luis' frolicsome and chatty character usually stood out and jokes were common among the staff. A dartboard hanging on the door, below a framed picture of Humberto Rotondo, added to this mood. It was also common to find some of them having lunch together or celebrating special occasions in the hospital cafeteria. Luz confirmed that group relationships were good. "We are close and understand each other very well. The work we do is teamwork," she told me.



Figure 4. The dartboard and Humberto Rotondo.

They were quite open with each other and Luis delegated important tasks, such as coordinating the implementation of programmes with other groups or institutions, to the two senior psychologists, Elizabeth and José. José had been in the Department for six years and, I suspect, he must have been of great help when Luis first arrived some months ago. Elizabeth once joked that he was the real source of power within the group.

Psychiatry and psychology are two professions that overlap significantly. According to some of the psychiatrists I interviewed at the two hospitals, approximately between 50% and 70% of local psychiatrists have formally studied a psychotherapeutic approach. Luis, for example, had finished his residency recently and did not have any formal psychotherapeutic training. He came from a neurobiologically-oriented psychiatric unit, but felt the need to acquire psychotherapeutic knowledge to apply for his private practice. During another van ride in the trajectory to Huaycán, Carmen asked Luis if the systemic therapy book she gave him had been of use. It is worth noting here that a student giving advice to a psychiatrist might be something rare in other hospital spaces where relationships are more hierarchical. Luis answered that the book was indeed useful because he is seeing couples in his private practice: “It is like ‘Laura en América’ (a talk show where fights between couples were common). If you do not know couple therapy, you will not know how to act. Each one blames the other and they expect you to be on their side.” I witnessed many discussions about different kinds of psychotherapies and which ones were preferred by members of the team. This was a big topic, perhaps, due to the presence of four psychologists and other professionals who were also interested in the subject, such as Luz or María.

Another instance of interface and cross-fertilisation between psychiatry and psychology was when Antonio joined me and Luis in patient consultations one day. This was not usual, as in his case instruction duties fell on senior psychologists and the role of interns in the community centre was to offer psychological advice to the public. But work was slow that day and he asked Luis if he could watch him. Luis addressed his presence didactically, asking Antonio to help him in the psychopathological evaluation of the patient and suggesting different categories of analysis that he could use, such as rhythm of discourse or style of language. This interaction displayed the latent



possibilities of communication between the two professions, illustrated by shared structures of thought and language.

Luz also showed interest in the psychiatric and psychological domains. She attended the national psychiatric congress during the time of my fieldwork and kept track of the psychotherapy courses that were being offered by local institutes. I also saw her participating in the discussion of patient cases with the psychologists. In this way, although each profession has a defined set of differentiated roles in the project, the lack of rigid spatiotemporal boundaries separating them—like the ones present inside the hospital—allows for more collaborative and fluid interaction.

There were also some instances of disagreement. It was common for psychologists to pass on patients to psychiatrists. They did this when they found symptoms regarded as severe and in need of medication (suicidal thoughts, for instance). The psychiatrist then evaluated the person and decided if it was indeed a psychiatric case or not. Sometimes the standard of what constitutes a psychiatric case was revealed to be an equivocal matter. On one morning, Carmen had referred two patients to María and one of them was not deemed a psychiatric case. The genuine one was an adolescent who had been sexually abused by her father years ago and was now depressed and had suicidal thoughts. María also diagnosed her with borderline personality disorder. The other case was a mother who was sad because she found out her child had a homosexual experience. Going back to the hospital in the van, Carmen commented: “That lady was very depressed, wasn’t she?” María replied that it was not an established depression, but an adaptive one. This meant that she perceived the woman’s sadness as a reasonable reaction, or “adaptation”, to an event. In order for it to be psychiatric material, the reaction should either be considered not commensurate with the event, be too severe, or have an excessive duration.

I also found the opposite situation, where the psychologist did not consider a case as psychiatric but the doctor did. Luis once came across a patient who was looking for José and decided to evaluate her. She had been depressed due to being physically abused by her partner and had finally left him. Although José had not sent the woman to a psychiatrist, Luis concluded that she needed medication and wanted to continue seeing her.

The two social workers were more distant from the rest of the group and Luis seemed to have some authority issues with them. When discussing a specific episode

when one of them was reluctant to take a patient to another establishment, Luis told me that “it is difficult when they are older people, they are not receptive.” But the most strained relationship was the one between Luis and María, the two psychiatrists. I witnessed him get irritated and reproach her publicly on a couple of occasions. It was also made clear by frequent misunderstandings regarding different aspects of María’s work that communication between them was not optimal. Luis defined her as “conflictive, impulsive, and critical”.

María, for her part, thought the team lacked motivation. She only lasted two months in the job because she took a new post, with a better contract, in another department of the hospital. “It is for the best”, she told me. “People here are too slow, they arrive late... I get here and I have to wait for them.” She added that “the reform project will not progress because the people here do not like the topic and, hence, are not too motivated. They spend their day sitting (in the community centre) and waiting for their time to leave”

The leaving time was also an issue underlined by María. On her first day of work in Huaycán, she came back to the centre, from another health establishment where she was carrying out a training session with a doctor, later than expected and the other team members speculated that she had probably stayed seeing patients herself at the other place. María tried to justify this by saying there were suicidal patients who could not be ignored. Similarly, psychiatric consultations in the community centre had to be halted at times because the rest of the team wanted to leave. She contrasted this type of disposition with her own when she worked in rural primary care establishments, before doing her residency at Hospital Valdizán, where she used to stay until late and be available at any time.

## Psychiatry in the Community

Besides the fact that there is more time available for each consultation and that patients can be seen more frequently, the therapeutic encounter at the community centre does not take a different form from how it occurs in the outpatient unit of Hospital Valdizán, so I am going to leave that analysis for chapter five. Here I want to focus on reflecting on psychiatry’s engagement with the social and cultural context of patients.

Psychiatry perceives people and communities in an abstract way, not enmeshed in individual biographies and social environments, but principally through the lens of psychological and psychiatric categories of mental disorders. For example, the chief of the hospital's Community Psychiatry Programme of the 1980s stated in an article that, taking as a reference studies made in another district of the capital, the area of the hospital should have 9,400 alcoholics, 2,982 epileptics, 1,491 schizophrenics, 10,813 depressives, and 17,150 anxious people (Bazán, 1983, p. 194). La Reforma's team reported a similar quantitative view of the community in the baseline study they did at the beginning of the project: 45% of people with mental disorders did not receive any professional help, life time prevalence was 33.3% for anxiety and 21.4% for depression, 9.1% of the interviewees could not abstain from consuming alcohol, etc. (Navarro, 2011, p. 16).

Although the baseline study expressed the intention of paying attention to local context before initiating an action plan, it describes Huaycán and its problems in a narrow psychiatric approach instead of delving into the people's own manner of defining their mental health and taking popular health culture into account. Local ways of expressing maladies come with distinctive concepts of illness causation, forms of expertise and practices, and alternative therapeutic services. Given that migrants from different regions of the country inhabit areas like Huaycán, one can find a rich array of popular health ideas and practices in households. In the case of mental health service users, specific curative practices—such as preparing black dog head soup or taking commercial vitamin supplements—were accounted for by hospital psychiatrists.

María, for example, resumed the usual therapeutic itinerary of a hospital patient in the following way:

They bring him here because he is already aggressive. He has hit someone, killed someone, or did something very bad. First they have to take their special soup, or they have taken him to the all of the local healers, or to different religions where they have been told that God will cure him and all of that. And then they come here. Because they are migrants, they believe in all of that stuff.

She and other psychiatrists alluded to the habit of visiting local healers in cases of psychosis. Other sources of psychosocial support for many service users are religious congregations of different kinds. For example, there was a middle-aged woman who

dropped by the community centre telling Luis she had ran out of fluoxetine. She was usually seen by a general practitioner from Huaycán's hospital, one of Luis' trainees, but he was on holiday. Before leaving the centre with her prescription, the woman gave me a Jehovah's Witness magazine. She was lonely and entirely dedicated to caring for her mother and had been depressed and anxious. But when she entered the cult, she met and married another member and considerably improved her mood. Luis and her doctor where gladly surprised that she had got married.

These expressions of local culture did not show up in the consultations I witnessed. Psychiatrists are, to an extent, aware of them and they talked about it when I asked them, but they were not part of the clinical encounter. They are not regarded as useful information. They can be viewed, however, under a negative light and as a potential threat to psychiatric treatment. Noguchi's epidemiological study of Lima, for example, calls them "myths" and "prejudices" (Saavedra, 2002, p. 29). I also found an instance of this when I was observing a department chief give a general overview of Hospital Valdizán's work to a group of US medical students who were visiting the premises. In one of his PowerPoint slides, the area's migrant population and cultural diversity were listed under the suggestive title of "threats".

Even a more progressive study made by Noguchi psychiatrists that set out to explore local manifestations of mental distress shows a clear bias towards psychiatric nosology in its final recommendations. In order to "fill up the existing knowledge gap between the community semantic environment and the mental health professional" (Perales, Montoya and Sogi, 1995, p. 109), the authors outline two possible interventions:

To investigate if the popular criteria not mentioned by the scientific model is a prospective scientific point that should be given due consideration; and, in those well established scientific psychiatric diagnostic criteria, but not mentioned in the popular system, to educate the community about them, so to guide the participation in early detection of cases and their proper reference to Mental Health Services (Perales, Montoya and Sogi, 1995, p. 111).

Instead of advocating the use of local data to understand people better and provide a culturally sensitive service, the authors recommend to verify if popular categories are worthy of being considered within the diagnostic practices of psychiatrists, expressing an underlying scepticism towards them.

Perhaps the only salient local feature I saw that was accepted as a legitimate resource was religion, possibly because it is thought as less interfering and even having positive effects on patients' lives. Luis, for instance, told me that evangelical ethics were an effective source of behaviour modification that could help with problems such as domestic violence.

The patients' socioeconomic context is a more visible dimension in consultations. Huaycán is a place where new settlers illegally take lands on arid hills. These young communities suffer the troubles of many marginalised urban areas: extremely harsh environmental living conditions and other structural constraints related to employment, diet, transportation and other public services compose a scenario that is not easy to deal with. Psychiatrists are aware of these poor living conditions and they do take them into account when engaging with patients. On one consultation, for example, Luis told a patient that he wanted to see her again but did not prescribe her anything. Surprised by this, I asked him if he also treated people without medication in his private practice. He answered that she did need medication but did not have money, so giving her a prescription would mean putting more stress on her. Thus, in taking a flexible approach by adapting his craft to the person's specific conditions of livelihood, instead of blindly prescribing pharmaceuticals, Luis was making it easier for her to keep attending consultations.

As this case shows, psychiatrists can take the socioeconomic condition of the patient into account when making therapeutic decisions. Practitioners can also address this dimension through counselling. Luis, for instance, frequently centred his attention on women's economic situation. He advised them, with much insistence, to get a job in order to maintain their children and break the ties of dependence with their husbands or families.

But when it comes to thinking about poverty itself, a fatalistic approach may be brought to the fore. Luis told me about a woman with three children whom he saw once in a region of the Peruvian Amazon: "They lived in a tiny space and their lunch was a dirty carrot, an onion and animal skin hanging with flies. The doctor's insensibility did not help, it really got to me. That type of poverty should not exist, but since we cannot do anything about it, we take it from there." This view is echoed in Hospital Valdizán's institutional plan, which expresses that the hospital does not intervene in the social determinants of health (Hospital Hermilio Valdizán, 2012, p.68).

The social determinants of mental health are seen as beyond psychiatry's scope of intervention. By providing medications and advice on ways of coping with personal problems, the psychiatrist is empowering patients to overcome their hardships. In other words, he or she is helping them adapt to their own conditions of living. By acting upon the socioeconomic forces that impinge on people's lives, however, psychiatry would be enhancing the living conditions to which they need to adapt.

María, for instance, told me that real mental health promotion would be to work in dealing with the problems of the community alongside the people and other institutions. The programme does go beyond the individual and into the family as a site of intervention. According to Director Navarro, this idea was developed along the way: "One of the most important lessons is that we are not going to achieve anything if we do not reach the family. Thus, we have included the PAHO programme Familias Fuertes." In this way, they are recognising family relations as a determinant of individual mental health, but the broader conditions of living that affect families, such as poor working conditions or lack of services, are left unattended.

## Community Relations

One of the project's strengths has been its political strategy, which has included establishing bonds with key community representatives such as Huaycán's central political committee and parish. The community centre was provided by the latter organisation. Parish San Andrés developed an intimate and participative relationship with the community from its beginnings. Tadeo Passini, an Italian priest, was a frequent visitor of Huaycán when the first settlers arrived and became popular among them by taking part in communal work. He stayed in the area and devised a system of grassroots ecclesiastical communities (CEBs) that were created in many neighbourhoods (Comisión de la Verdad y Reconciliación, 2003, p. 435). Today the parish offers medical services and the supportive work they used to carry out with mentally ill individuals was handed over to Hospital Valdizán.

Despite these strategic actions that sought to establish close bonds with the community, the pilot project's reform component had weakened the community centre's relationship with patients. Mental health provision had not been dropped by the project,

but it had been modified in ways that reflected the greater emphasis placed on the transformation of the system. Milagros, one of the social workers that had been in the Department of Mental Health Promotion before the current project was launched, illustrated these changes:

There has been change in the service. Before, we served the community. There were no references at that time, we dealt with every case. On Tuesdays and Fridays problems were resolved. And when the case could not show up at the service, all of the team would go to the house, including the doctor, and see the case there.

This quote evokes a closer relationship with the community and an expanded form of service: sending patients to other health establishments was not an option because they aimed to provide the service themselves. The present project, with its stress on services reform, has shifted its attention from offering therapy to the community to promoting the dissemination of therapy through different institutional trails (the health system, the educational system, NGOs, local government, the family, etc.). References, now encouraged, are the mechanisms through which the system is made to work. They serve to allocate patient care according to the level of complexity of each case, rather than subjecting the whole mental healthcare spectrum to the psychiatric hospital. The community centre is not regarded as part of the system in the scheme of the project. Rather, it is seen as an external hand offering temporary help to the system while it undergoes transformation.

Although the community centre was a better option for patients due to its proximity and enhanced availability (waiting lists were shorter and consultations longer than in the hospital), the quality of service offered by the team was decreasing. To illustrate this with an example, patients sometimes expressed their desire to see the same psychiatrist or psychologist each time they went to the centre. This was not standard practice, however, during my time there. Psychiatrists were not seen as having exclusive jurisdiction over cases and whenever they were unavailable, other practitioners could take over without there being any complications. This situation was fairly common because Luis, as head of the Department, was often distracted by other activities. He held frequent lengthy meetings with Director Navarro and was particularly burdened by a new project he had been ordered to develop (a bullying campaign in

public schools). He lamented this because, being a small team, they already had enough on their plate and spontaneous initiatives like this one took a toll on their work.

These distractions, and other incidents that sometimes caused the team to arrive late at the community centre, led to absences and delays in the service. In this regard, the hospital was more trustworthy because it held constant service hours. This had a negative impact on patient attendance to the centre. In his review article of the project, Navarro (Navarro 2011, p. 21) highlighted that the community centre had received a steady flow of new monthly patients during its first year of activity. The team also told me the centre's patient demand was optimal. According to Luis, they had on average 33 new patients per month and more than 500 in general. However, they were aware that demand was currently dropping due to their involvement in the bullying campaign. "People get tired", Luis observed.

Elizabeth eloquently expressed a more general tendency of unstable participation in the team's different activities:

It is complicated to achieve the goal of making families finish the Familias Fuertes programme. In communities it is usually difficult, most people quit. We are looking at strategies for retaining families but it is a bit complicated. We also see that the school doesn't collaborate too much with us. It could make appointments with families or make them remember. We should, perhaps, study what is happening, for which reasons a family witnessing that this is helpful and good for them does not attend. It could be lack of time or interest, I do not know. You do not only see this in the programme with families, but also in the service. They come three times and then do not return. In general, that always happens.

The team was experiencing the complexities of addressing, with limited resources, the mental health of a migrant population in a context of urban poverty. This last quote illustrates the distance that separates them from the population and a lack of understanding of the determinants of community participation.

## Training Doctors

La Reforma favoured task-sharing as an avenue towards the reform of mental health services. Luis emphasised the importance of early detection of mental health problems in primary healthcare: "A depression in its initial stages is not the same as one that has



been going on for two years. The first treatment has to be the definitive one, rightly applied, in order to prevent chronicity.” But mental health problems, Luis argued, go unnoticed in primary healthcare or, if they are detected, doctors do not know how to deal with them. So the task-sharing programme of the project included not only training general practitioners to detect, but also to diagnose and treat patients with psychopharmaceuticals. They would also teach doctors to recognise complex cases that should be sent to specialised services. Other health professionals such as nurses and obstetricians were trained in counselling.

The methodology chosen was in-service training. Luis saw this modality as an inefficient way of putting the team’s human resources into use because it required too much time. “I would prefer the doctor to come and observe me like you do. He would see more patients and could ask more questions,” he told me. But then he remembered that, according to studies, even under the internship modality of training, it is hard to make doctors incorporate mental health actions into their repertoire. He linked this to the stigma that mental health problems carry in the medical world and concluded that the best way of convincing physicians would be to include more psychiatric training in undergraduate medical programmes. The problem seems to be more complex than this, however, as my following description of the difficulties encountered will account for.

The primary healthcare centres chosen by the project did not carry out any mental health activities. Usually these are reserved for psychologists, but these professionals are hard to find in these facilities. Hospital Huaycán did have a specialised office of psychological services for violence victims and, thus, included a mental health component in its actions.

Only one of the three targeted establishments showed good progress while I was in the field. The doctor of this centre diagnosed and treated mild mental health problems and the nurse and obstetrician provided counselling. The team found resistance among the personnel of the other centre and of Hospital Huaycán, however. Luis did not want me to observe his training sessions there because of this. He commented that it was a tough job to train demoralised doctors. He could not get hold of one of them, who kept purposefully avoiding him, and managed to allure another by telling him that he could become specialised in psychiatry and make more money as a private practitioner.

Reyes (2007) shows how, in different parts of Peru, poor working conditions among primary healthcare personnel and a specific public sector labour regime generate

conditions of stagnancy in many of these facilities. She describes how employees tend to lose motivation over time and more proactive workers under temporary contracts view the position as a stepping-stone and end up leaving for other jobs. High labour mobility was pointed out by the project team as a mayor glitch in the training programme. In Luis' words, "doctors are like gypsies". The trained practitioners end up leaving and the establishment loses the work the trainers have done.

Another complication encountered by the team was prolonged public sector strikes. Both the training component and their work with school counselling units had to be paused for a month due to a couple of strikes organised by the national medical and education workers union, respectively. The main demand made by both groups was a salary raise.

In one of our visits to a primary care establishment, we were told to wait because the obstetrician had missed work and the doctor had to fill in for her. While we were seated in the waiting room watching television, Luis mumbled "I know how this is", referring to his days as a primary care physician.<sup>16</sup> With only three first-level health centres in Huaycán, I would have thought they were overcrowded, although Luis told me that some of them did not have too much demand. This can probably be explained by the fact that demand for primary care in Peru is concentrated in hospitals (Madueño and Sanabria, 2003, p. 25). Thus, the presence of Hospital Huaycán in the area alleviates the other centres' patient load. For the training sessions I observed, Luis and the doctor he trained, Dr García, had chosen the day in which the establishment was less burdened with patients.

Another dimension of the primary care job, related to the administrative regime of health centres, sometimes popped up in Luis and García's conversations. Comments such as "they have increased our cases", "I have to submit my report this week", or "you should incorporate mental health treatment into your goals", speak of a form of governance in the management of public services that is focused on maximising labour efficiency. The performance of workers is audited and they are stimulated to yield better results by conditioning their payment to their levels of productivity. María expressed concern over this matter, stating that paying attention to mental health problems does not favour the "productivity" of doctors, as this element is not measured taking into

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<sup>16</sup> Every health professional who wants to do a residency or work in the public sector has to complete a year of service in a primary healthcare facility after graduation.

account that mental health actions may take longer than other types of biomedical activities.

Given doctors' lack of interest or possibilities in providing mental health treatment, it is not surprising that consultants frequently ended up acting as frontline providers. One of the doctors, for instance, always wanted Luis to treat his tuberculosis patients. Furthermore, past team members and María provided treatment in Hospital Huaycán because there was no one to train and they felt morally compelled to see the patients who were there. Luis, however, was refusing to do this. He argued that it was not what they were supposed to do and that they could be penalised for irregularly treating patients in a workplace that was not theirs.

Luz expressed the team's frustration regarding these external limitations that thwarted their job: "We are frustrated because we have worked so much and are not seeing results. Even so, there is one establishment that is providing treatment. That makes us think that not all of the work has been in vain." This sentiment of futility was accompanied by a sense of powerlessness vis-à-vis the politics of the project and of health establishments. For example, one day the team, while Luis was not there, was gathered in the office discussing the difficulties they were experiencing. María, with her characteristic drive, said "if it does not get better, we should not keep going on". In a frustrated tone, the others replied that their superiors made the calls and they just followed orders.

In terms of the obstacles encountered within the health establishments, they thought there was not much they could do if policymakers or other health system bureaucrats did not implement changes that could enable favourable conditions for health personnel to include mental health into their functions.

## Training Sessions

I observed four training sessions with Dr García at a primary health care centre and one with another doctor from Hospital Huaycán. The former establishment had been responsive to training, while the hospital had not; but they eventually found a physician from the hospital, who was specialised in physical therapy, who showed interest in participating.

García's centre had just started operating some months ago. We travelled there in the van with Luis, José, and Luz on my first day with the team. While we were chatting, I contemplated the road through the window. At first the vehicle climbed the sloped paved central road where the community centre lies, lined with brick houses and a few small businesses uneven in their size and colour. As the van deviated from the road and into dusty paths, moving into the higher parts of the mountain, plywood, corrugated iron, and brush matting joined the bricked housing landscape. The van was taking longer than usual (it was only five to ten minutes away from the community centre) and they realised the driver was disoriented. "Huaycán is chaotic, it is easy to get lost," Luis explained.

We finally got there after a while and the van parked outside the facility. I could see the mountain surrounding Huaycán—mimicking the stands of a football stadium—much closer than before, giving the impression that we had nearly reached the end of the area. The primary care centre lied on top of a small and elegant stone and concrete retaining wall, which led to a patio. The building itself was a compact single-story structure made of concrete. The centre looked like an immaculate oasis in an otherwise rugged scenery. Even the stone retaining walls and plants that were ten metres away were different from the ones in the centre's perimeter. For me, it looked like the pristine hand of Western medicine, vertically introducing itself into a distinctively local environment where everything else was self-built.

Entering the premises, we encountered a waiting space with chairs and a television and, in front of this, a narrow office aisle stretched along for some metres. García's consultation room was the first one to the left. A small and white space, with a desk and an examination table, filled with health education posters. Both García and the doctor from Hospital Huaycán were young and had a friendly relationship with Luis, in contrast to the older doctors from the other establishments, who were less receptive. As early-career doctors, Luis and García had shared interests and concerns to speak about informally during the training sessions, like the time when they bonded over bad working conditions. They had a second-rate contract, which deprived them of benefits, and were discussing María's terms of employment within the Department, which were even worse. García said it is wrong to exploit doctors and Luis self-critically alleged that they have let this happen.

Both trainees had already detected people with mental health problems, such as depression or schizophrenia, and were treating them with psychopharmaceuticals. García struck me as being especially enthusiastic about incorporating psychiatry into his practice. He had a mental health poster on one of his sidewalls that read “Mental Health: screening services for violence, depression and alcohol” and had obtained a mental health care guide that he showed to Luis in one of our visits. When Luis brought up the national psychiatry congress that he had attended in another region of the country, García complained that he should have told him about it. This degree of interest took me by surprise and made me think he was, perhaps, considering pursuing a specialisation in psychiatry.

The training plan was composed of 12 weekly sessions with subsequent follow-up visits. The sessions I observed lasted between 30 minutes and an hour. Luis mainly taught the doctors about different mental health problems and gave them advice on the cases they were handling. On one occasion only he interrogated an actual patient while García watched. The topics seen were related to schizophrenia, depression, anxiety disorders, post-traumatic stress disorder, and addictions.

Luis came across as a skilled and didactic instructor. He made reviews after discussing topics and picked up on things the physicians said in order to delve further into specific themes. Something that really stood out in his style was the use of examples, the most colourful being the movie Rambo when he talked about post-traumatic stress disorder, or a caveman encountering a sabre-toothed tiger to illustrate how a person’s body reacts when having an anxious reaction. He also provided learning material. He handed over, for instance, a folder labelled “Psychopharmaceuticals” that I once saw in García’s backpack.

Luis’ psychiatric orientation became manifest when he occasionally explained the neurobiological correlates of disorders. For example, when discussing organic mental disorder, he told García: “Alcoholics and drug addicts become organics because their frontal lobe deteriorates. I’ll bring my laptop for the next session and show you PET scans of their brains.” Neuroimaging knowledge was surely of little use for a primary care physician, but it was Luis’ own contribution stemming from his personal sources of enthusiasm.

I realised that Luis’ orientation was, in some respects, fitting for the job when García asked him about TB patients and he had a lot to say about them. Luis had been trained

in a unit of liaison psychiatry and was therefore familiarised with the interface between medical and emotional conditions. In the end, the reality of a general hospital, in terms of the kind of patients it receives, resembles that of primary care more than mental hospitals, where less prevalent complex psychiatric disorders are the centre of attention.

There is a fundamental difference between practicing psychiatry in a specialised centre and within general medicine. In the community centre, for instance, psychiatrist Martínez knows that the person seating in front of him has some kind of emotional issue and can, thus, take a “naturalistic” approach to interviewing (hearing what the patient has to say rather than directing his or her discourse with pre-determined questions). In primary care, however, patients are there for different reasons and taking this approach means risking leaving underlying mental health problems unnoticed. Therefore, practitioners in these settings have to take a more active stance, they have to look for problems. Luis encouraged García to do this in their training sessions: “Have you seen anxiety? You will always find it. Have you looked for it?” He also prompted him to keep a steady flow of patients: “You are already handling patients, now you have to get more. Detect two or three and make them come on Tuesdays (the day of the training session). Working with patients is crucial.”

If the primary care doctor has to look for patients, he also has to maintain them. A key psychiatric tool for doing this is psychoeducation, which means convincing patients they have a specific disorder and teaching them about its symptoms, treatment, and ways of coping. In one of the training sessions, García talked about a patient who had stopped taking alprazolam abruptly and had not fared well afterwards. Luis, in response, promised to bring a “pathology almanac” that he could use for psychoeducation. He cautioned him that patients frequently abandon treatment: “I do psychoeducation for half an hour in my private practice and they end up leaving treatment after two months. You should not feel bad when this happens. And do not get angry at them because they will stop coming if they are afraid of you.”

Luis’ approach to teaching the doctor how to detect, control and refer a mental health problem can be seen in his following instructions:

The three key questions for depression are: Have you been sad for 15 days? Do you find it hard to do things that you did not find hard to do before? Have you

stopped enjoying things you used to enjoy? If this gives you a positive, you ask all of the other questions. Sertraline, one per day, is first-line treatment. You apply the Hamilton Scale for Depression (HRSD) so that you can quantify and see if the person has improved, although you can also see this in the interview. If it has decreased, you continue treatment. If not, you can increase the dose to two, and then to three. You have to keep prescribing antidepressants for a year minimum. If they do not get better, you have to change the pill and if you burn two treatment schemes and nothing happens, it could be treatment-resistant depression or bipolar depression and you have to refer them. One year without symptoms is considered to be complete remission. You slowly lower the dose of the medication. Half a dose, then one quarter of a dose for a month, then you take them off. Some patients will not want to quit the pills.

Psychiatric treatment here is reduced to a simple algorithm, based on a set of instructions and with the help of standardised tools like the Hamilton scale. This transformation of psychiatry can be linked to the specific conditions of primary health care, as the user's guide to the WHO's Self-Reporting Questionnaire (SRQ) indicates (WHO, 1994, p. 5):

Since such workers have only a limited training and are expected to cope with many pressing health problems, the need to limit and define the scope of mental health care provided at this level was stressed, so that only simple and circumscribed tasks should be included in their work.

Although it seems that a cookbook approach is more feasible in the light of the limited availability of knowledge and time in primary care, it risks losing sight of the full complexity of mental health problems by reducing them to a diagnostic and therapeutic technical scheme centred on the detection of signs and prescription of psychopharmaceuticals.

A different perspective has been advanced by the WHO in its document *Integrating Mental Health Into Primary Care: a global perspective* (2008), where it advocates for a more comprehensive strategy, including specific guidelines of cultural awareness and communication skills and the scaling-up of pre and post-service mental health training. This methodology, however, entails going beyond a quick-fix approach and tackling wider issues of health education curriculums and the political-administrative realities of health establishments.

In sum, I would say that the project team's strategy was sensitive to the reality of local services and they tried to accommodate to it as they could. In addition to this, Luis'

methodology and charisma was a positive contribution to the training programme. As I have seen, however, a broad national policy of mental health within the general health system is missing and the structural conditions of primary care services worked against the interests of the intervention. Therefore, as the team members reflected, a stronger engagement with mid and top-level politics is needed to ensure a better prospect. This could also allow for a richer inclusion of mental health in primary healthcare, one in which the understanding of mental health problems is not reduced to quantification and technical knowledge.

## Discussion

In this chapter I have examined a project that intended to disseminate psychiatric knowledge and the use of mental health services in the area of Huaycán. In a milieu where few are interested in public health and community practice, Director Navarro perhaps devised a plan that was too ambitious for the resources he had available. In its journey into “the community”, psychiatry meets and deals with other institutions such as primary health care services and public schools. As I have seen, public health structures posed a serious challenge to these encounters. Additionally, the social distance between providers and patients and poor living conditions further complicates the job. This resulted in the project team members encountering considerable difficulties and feeling frustrated about their inability to produce substantial results.

As I have described, the Department of Mental Health Promotion was implementing a task-sharing initiative and psychiatrists were training primary health care doctors theoretically and supervising the care they were providing to patients who had mental health issues, a model of training that has been found to be effective (Kaiser and McLean, 2015). Task-sharing supporters state that it is a cost-effective strategy (Patel, 2015, p. 22) for enhancing access to mental health treatment in countries where there is a shortage of specialised care (Patel et al., 2013, p. 1). However, the programmes that global mental health advocates champion have components that were missing in Hospital Valdizán’s task-sharing project. Doctors, nurses, and obstetricians were trained in the detection of mental health problems, medication management, and counselling. Psychotherapies (Patel et al., 2013, p. 3) and lay (Patel, 2015; Kaiser and McLean, 2015) and peer mental health workers (Myers, 2015a; Hall et al., 2017) were



not considered in the intervention scheme. Lay and peer care providers could potentially reduce the social distance between the service and patients, given that Huaycán locals who have suffered, or not, mental health problems could take these posts.

Another set of findings that resonate with what has been said about task-sharing initiatives in the literature is that they may find obstacles in local healthcare platforms of low and middle-income countries. Acceptability of task-sharing by healthcare staff (Mendenhall et al., 2014) was found to be an important variable. The project team encountered resistance from professionals in two of the three establishments in which they wanted to perform the trainings. As I have reviewed, working conditions in public healthcare centres can negatively affect staff's willingness to provide mental health care. The project also suffered short pauses because these public sector workers went on strike in order to demand salary raises. Similarly, authors have pointed to the insufficient funding of health services and workforce in low and middle-income countries (Patel et al., 2016, p. 3077; Mendenhall et al., 2014, pp. 37-40) as a factor that may impair the viability of task-sharing programmes.

In addition to revealing psychiatry's tough road towards reform, I have developed a critique of psychiatric practice. I point out it has a narrow scope, concentrating on individual maladies and the development of services, while losing sight of the broader socioeconomic and environmental determinants of mental health. By the same token, Mills and White (2017, p. 197) assert "the need to move away from the individualization of distress by calling attention to the structural determinants of mental health and well-being more widely". Furthermore, I have argued that psychiatry remains distanced from popular health culture and perceives it as a possible obstacle. Anthropologists have shown how this distance can generate tensions that can result in failed clinical encounters and users' resistance towards psychiatry (Gaines, 1982; Wilce, 2004; Tran, 2016; Marrow, 2013; Orr, 2013; Koss-Chioino and Canive, 1993).

I want to mention here a third critique related to the hegemony of psychopharmacology as a therapeutic option. While the community centre offers psychopharmaceuticals, it avoids psychotherapy under the pretence that it is too complex for it to be used at a community level. Thus, psychiatric drugs are favoured over psychotherapies, probably because there is a lack of human resources that can apply them or due to psychiatric drugs being easier to hand out. In this way,

psychotherapy remains a scarce good in the landscape of mental health service provision. If psychiatrists thought a patient needed it, they had to refer him or her to Hospital Valdizán. Private psychologists were rarely considered as an option due to patients' economic constraints. Moreover, a possible contingency in the Valdizán referrals was related to the fact that every patient arriving at the hospital has to see a psychiatrist first and, given that he or she can change the course of treatment, this potentially affects their possibility of seeing a psychologist.

Prescribing psychopharmaceuticals in a setting such as this one is not a smart move from a public health stance. Neither the community centre nor primary healthcare establishments had these medicines to give out, they only provided prescriptions. Thus, even though the community centre was closer to their homes, patients had to travel to Hospital Valdizán anyway in order to access medicines at a discounted price. As observed by practitioners themselves, this and other complications result in patients taking psychotropics in an intermittent manner, which begs the question of whether it is sensible to introduce them in precarious socioeconomic and institutional environments. Kohrt and Jallah (2015, p. 271) echo this line of thought when they point out that marginalised individuals frequently oscillate from being overmedicated to not taking psychiatric medications at all.

Finally, the prominence earned by the services reform agenda in Lima results in psychiatry moving further away from the community. In the case of the Valdizán project, the emphasis placed on reforming services made the team back off from their former position of frontline providers and divert their attention towards other tasks. Concurrent to this is a sense that community psychiatry is a pointless task, while the training of health personnel from other establishments is what the hospital should concentrate on. In this way, the dissemination of psychiatry—coverage—is valued over the type of relationship—quality—it has with the community. In the following chapter I will concentrate on Noguchi's Collective Health Department, which has a richer tradition of community psychiatry than its Valdizán counterpart and where the contraposition of the reform and community stances was rendered explicit.



## Community Mental Health at Instituto Noguchi

### Castro de la Mata and the Beginnings of Noguchi

Renato Castro de la Mata became interested in psychiatry under the guidance of Carlos Alberto Seguí in the psychiatric service of Hospital Obrero and had a prominent role in Seguí's short-lived institutes of social psychiatry. He did his residency in the Allan Memorial Institute of McGill in Montreal and returned to Peru after five years, where he carried out family research in an Andean region and established his private practice. In 1971 he began working at Universidad Peruana Cayetano Heredia (UPCH), where he created a community mental health project that operated within a broader community medicine programme in the neighbouring district of Independencia. His main endeavour there was to establish a Counselling Centre for Children and Families in a facility provided by a Catholic congregation (Alva, 1988).

In 1980, the Japanese government donated a community mental health centre to Peru, which was initially called San Juan Bosco. This was the result of the friendship that Humberto Rotondo and Masaaki Kato, who was director of the Japanese National Institute of Mental Health, had formed in international WHO conferences (Castillo, 1988, p.169). It was decided that the project should be developed in the northern part of Lima, an area which did not have a mental hospital, and a large establishment was built on one side of UPCH. Castro de la Mata, who had been working in the area since 1971, was designated as the psychiatrist in charge. In this new setting, he migrated the programme from the counselling centre he had set up to seven different primary health care centres in Independencia and San Martín.<sup>17</sup>

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<sup>17</sup> San Martín is the district where the new community mental health centre was situated and Independencia is a neighbouring district. They were both composed by diverse rural haciendas until the massive illegal invasions of land, mostly by migrants from other regions of the country, took over Lima's surroundings. The invasions in San Martín started in 1945 and it was officially designated as a district in 1950, while in Independencia they started in 1960 and the district was

However, the Ministry of Health asked the Japanese if they could turn the community centre into a national institute and, after receiving a positive response, the Instituto Nacional de Salud Mental Honorio Delgado-Hideyo Noguchi was created in 1982 (Mariátegui, 1988, p. 239). Castro de la Mata was appointed as Associate Director, Javier Mariátegui being the first Director (Mariátegui, 1988, p. 241), and his two-year community programme was incorporated into the new institute as the Department of Community Mental Health. The other therapeutic departments created were Adults and Children and Adolescents (Mariátegui, 1988, p. 94). The cooperation project also included sending Japanese practitioners to the institute and funding internships in Japan for Peruvian psychiatrists (Mariátegui, 1988, p. 102).

Castro died of illness in 1988 and the department went on without him, but he is remembered to this day as a great leader. In the one-story wing where the department operates today, I found the last room of the hall has his name on the door and a photograph of him hanging on the wall. The word “mystique” kept coming up when people remembered him and the department’s early work, like in the following quote of a first-generation Noguchi psychiatrist:

Renato was a community mental health believer and he formed the department with a couple of young doctors and plenty of nurses, to whom he gave an extraordinary work mystique, he was very devoted. I think that he has been one of the strengths of the institute. Outstanding nurses were formed there. That programme had a lot of mystique.

This term denotes the ability of Castro to generate a morally charged and effective rhetoric around community mental health work, and facilitate a stimulated work environment by transmitting the deep faith he had in the project to his team. One of the nurses described their time with Castro as an “unforgettable experience” and an “opportunity that profoundly impinged on our professional development”.

He was also praised for his personality traits: persevering, warm-hearted, hopeful, and committed. This last quality was exemplified by the way he proceeded in the last years of his life. He reportedly maintained the same amount of energy and dedication to the department even in the worst stages of his illness (Mendoza, 1994, p.196; Castillo,

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created in 1964. At present they are large working-class urban centres of 500,000 and 200,000 people respectively.

1988, pp. 169-170). A colleague of his depicted in an article the type of relationship and commitment he developed with his patients by describing his last encounters with them. The last consultations were in his own bedroom, using fluffy cushions because of his bone pain. Castro chose to keep meeting them because, as he explained, for some patients just seeing their therapist was the most important treatment (Perales, 1999).

Finally, he is said to be a pioneer, having developed a modality of primary mental health care before the Alma-Ata Conference took place in 1978 (Alva, 1988, p. 133).

## The Principles of Community Mental Health

The work of the Department of Community Mental Health was based on a number of principles that Castro held and that I will mention in this section. As I will demonstrate, he was interested in developing a comprehensive methodology that included preventive and promotional work, the management of mental health disorders, and rehabilitation activities related to the chronically ill. Castro strategically positioned each one of the mental health professions in different parts of the community map: nurses worked within primary health care establishments, psychologists within public schools, and social workers in community organisations. I will start by exploring the work done by the first group in the fields of treatment and rehabilitation.

A basic tenet of the programme appeared, as a quote of Castro de la Mata, on a wall within the department: “The real treatment of patients is in their community”. The word “real” implies that treatment within the community carries a higher value than its hospital counterpart.

They started operating in seven primary health care establishments and eventually reduced their work to four (two in Independencia and two in San Martín) because they could not manage the workload. One main objective was to integrate mental health into public health (Alvarado et al., 1987, pp. 34-35). Rather than integrating to the health centres as a mental health team, they wanted to integrate into the programmes that already existed (mother-child, growth and development, school programme), adding mental health content through consultancy, education, and practical training (Mendoza, 1994, p. 196). This was how they started working next to primary care nurses in the public health programmes devoted to child care, tuberculosis, family planning, etc. One nurse told me that “medicines were not provided to patients in the community”. In other

words, this was the integration of a low-complexity, non-medical, form of mental health. Eventually, however, their work took a specialised turn with the creation of a physical space within the health centres labelled as the mental health service, due to the great level of demand.

Another hallmark of the programme was that nurses were handed more responsibilities. They evaluated patients in the health centres, then held meetings with the psychiatrist where they would decide on a diagnosis and treatment plan, and they were then in charge of conducting follow-up care. Nurses also had a prominent role in what was called the “the invisible hospital”, a comprehensive programme for people with schizophrenia that had the aim of preventing relapse and hospitalisation rates, and achieving social reintegration by providing care and rehabilitation services for patients in non-institutional environments. Patients from the seven health centres were seen in consultations and at home, patient support groups were formed, a couple of day hospitals were set up where basic clinical rehabilitation was undertaken, and workshops were organised where patients would produce textiles and crafts for their economic benefit. These efforts were reported to have succeeded in decreasing hospitalisation rates among patients that were part of the programme (García and Perales, 1989, pp. 180-181).

What stood out about the programme for observers was that some of the roles that had until then been under the jurisdiction of psychiatrists were now being enacted by nurses. Nurse Sánchez, a veteran of the department, told me that, at first, some psychiatrists accused this of being “second-class medicine”, but now it is widely seen as good practice in community services. She added that, over the years, this approach has evolved from being conceived as a simple delegation of roles to differentiated spaces in which each profession has its own contribution. The other professions are not passive performers of the psychiatric job, but agents with specific sets of skills that contribute and give shape to mental health services.

Castro de la Mata argued that psychiatry should, in addition to treating disorders and their sequels, promote good health and prevent disease (Castro de la Mata, 1987, p. 30). In relation to this view, he saw children and schools as the gate through which they could access families and teachers and the best place to carry out prevention (Mendoza, 1994, p. 196). By training teachers and through direct intervention in public

schools, they have focused mainly on treating disorders in children and preventing domestic and non-domestic violence.

Another key principle held by Castro was community participation (Alvarado et al., 1987, p. 35). Different articles about his ideology and work show that he favoured a participation model that sought to include the community's voice into the development of the mental health programme. He believed in "popular wisdom" and thought that the programme would succeed insofar as the community is involved in the stages of planning, implementation, and evaluation (Mendoza, 1994, p. 196). A former colleague described him meeting with community leaders and health professionals "to see what they wanted, their felt needs". There was also a sense of horizontality denoted in the language used by the community mental health professionals. They worked "with" the community, they "talked with" school teachers, and saw local people as their peers (Jáuregui, 1996, p. 30). Furthermore, their work has also included the mobilisation and empowerment of patient, family, and community groups towards the realisation of a wide array of mental health promotional tasks. Nevertheless, the omission of curanderos (traditional healers) from historical accounts of the programme suggests that the inclusion of local views and resources was not unrestricted.

Finally, Castro was described as socially conscious or socially committed (Mendoza, 1994, p. 194-196; Castro de la Mata, 1987, p. 30). The team was attentive towards the links between living conditions and mental health (Castro de la Mata, 1987, p.29) and the importance of intersectoral coordination for tackling these broader issues (Jáuregui, 1997, p. 179). Accordingly, they engaged in "community development" work in recently created urban settlements, addressing basic needs by planning and implementing activities in conjunction with community leaders. This represents a model that consists in "searching for and supporting the horizontal, as opposed to vertical, agendas that derive from organic local processes" (Janes, 2004, p. 465).

Castro himself felt compelled to develop a practice that would go beyond the individual model of psychiatry. He thought that private practice was a waste of time because of the limited amount of patients that are seen in that sphere (Mendoza, 1994, p. 195). One of the programme's nurses wrote that they sought to participate in the community's social predicaments and become part of its history, rather than just treat patients in the consultation room and work for a salary (Jáuregui, 1996, p. 31). This



adds a new meaning to community participation, one that is not related to the people's involvement with the health programme, but the other way around.

Although Castro de la Mata was not against politicisation—he perceived it as instrumental in the empowerment of the community (Castro de La Mata, 1987, p. 30)—it was an element that could be perceived as conflictive. A colleague who worked with him in the 1970s recalled that Marxist ideology had distorted primary healthcare projects of the time and claimed that the hubris shown by Marxists was unjustified because a leftist political ideology was not a necessary condition for advancing the health of the community. In her view, everyone involved in community health should collaborate, regardless of ideology.

There were a couple of instances where politicisation within the community mental health cohort led to conflict and exclusion. Leftist social workers and sociologists who were too critical were separated from the group during the 1970s. According to a psychiatrist who was part of the Department of Community Mental Health from its beginnings, Castro had initially begun working with sociologists, but had to throw them out because they alleged that doctors did not want to go into the communities. This critique was seen as dangerous because Peru had a leftist military government that could take measures against the university.

## The Decline of a Tradition

I met Dr Flores on a Thursday afternoon at the health centre where he was established. In order to get there from the Institute, I had to embark on a two-bus journey lasting thirty minutes into the heart of Independencia. The facility assigned for psychiatric work within this establishment was better than the tiny rooms I had seen in the other centres where the community mental health team is present. Based in the second floor of a two-story building in the patio of the health centre, it had its own spacious waiting room and two separate offices where the psychiatrist and a nurse saw patients. I encountered a room full of people when I crossed the doorway, and a secretary sitting at a desk facing them. I asked her if I could see the doctor and she told me to wait until he finished his consultation. I sat down and gazed at the timetable on the wall in front of me that showed their weekly activities and the people in charge of them.

Dr Flores soon left to use the bathroom outside the premises, and a lady told the waiting people they had to understand because he is the only psychiatrist for 300,000 inhabitants and that they should look after his mental health. She went on to say that their work there is rooted in vocation, despite having Noguchi against them. Four years ago they tried to close down the place, she continued, but patients protested and sued the institute, finally accomplishing the subsistence of the service. Noguchi, according to her, still wants to shut it down, but they will wait for Flores and the nurse to retire first. She also encouraged the attendees to officially register their family organisation and talked about stigma and other mental health related topics. “I am also a patient,” she revealed, “I was in bed due to depression, but now I am better and wanting to do something for my community.”

The psychiatrist and the nurse then invited me into his office, where I briefly told them what my research was about. Dr Flores embarked on a monologue: “Here we do consultations, but our work is more than that. You have heard what has been said outside, we promote family organisations. We also have a suicide prevention programme.” He talked about the antagonism they face from the institute and that he hoped my research would represent his side of the story. We agreed to continue our talk another day, which we did in one of Noguchi’s outpatient consultation rooms.

Over the course of my fieldwork at Noguchi, I came to see that the community mental health group had developed a degree of isolation from the institute. A psychiatrist from another department told me that when the institute celebrates an anniversary, Collective Health<sup>18</sup> always celebrates one more year because their work had started before the place was turned into a national institute. He observed that their autonomy has led to administrative ambiguities in the work they do at the primary health care centres. Even though officially they are Noguchi workers, their work responds more to the needs of these centres rather than the hospital’s directives, and the clinical charts they use stay on site instead of being sent to the institute. “What happened here was an exportation of psychiatrists, alienating them from their source,” the practitioner stated.

This alienation did prove to be true in the case of a group of people I met at the Collective Health Division. In the same way as Flores and the nurse at Independencia,

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<sup>18</sup> This was the new name of the Department of Community Mental Health.

a nurse and a social worker worked full-time at another health centre, while most of the others in the division participated in Project Apurímac (a services reform project that was being implemented in the division), in addition to their service work. This social worker referred to the health centre personnel as “workmates” and indicated a diminished participation within the institute: “In the health centre we work as a team. We also coordinate with the institute, with the Division of Collective Health, because we are a part of that. We have to go to the meetings. Sometimes this is difficult because they do not cover transportation expenses and, also, due to our workload here. We participate, but not 100%.” They were involved in the institutional life of the health centre, partaking in activities such as in-service training schedules or the tuberculosis programme.

With the demise of Castro de la Mata in 1988, the initial appeal that community mental health had within the institute’s founding group became weaker and continued to progressively fade until present times, when Noguchi’s policy is to prioritise hospitalisation and outpatient services. Nurse Sánchez described how they faced serious obstacles in the first years due to the way in which the institute regarded community work. When Community Mental Health Centre San Juan Bosco became Instituto Noguchi, they were given the option of leaving the community and working within the premises, which a large amount of people did. “Naturally, the premises were very nice,” she explained. They were initially not considered within the organisational structure of the Institute, a position from which they would have struggled to garner resources, but were ultimately given consideration, according to Sánchez, thanks to the leverage of the Japanese mission, the patients from the community programme, and Castro de la Mata.

Sánchez evoked a spatial dimension in the conflictive relationship with the institute. The community department has remained closer to the external world, beyond Noguchi’s walls:

There has always been that tension with the other departments of the institute: ‘What is it that you are doing outside?’ Being outside has led us to become acquainted with other social actors. For example, the PAHO, the Ministry of Education, NGOs and international organisations. They have helped us. Also the School of Public Health at Universidad Cayetano Heredia. There has been a parallel development for us. But, internally, we did not have much prestige.

Dr Flores also talked about the antagonism shown by colleagues from other departments. He claimed to have been openly discriminated and to have heard people say “Castro de la Mata is dead” as a way of expressing their disavowal.

The personnel that were entirely dedicated to community mental health complained that they did not receive any resources for their work. Nurse Sánchez spoke of a blockade that has been in place against their department. In addition to this, the number of workers is meagre, considering the amount of work they do. A social worker had to cover two different health centres by herself and, added to this, participate in research done by the division. “Naturally, I am not going to achieve good work, I do what I can,” she told me. A nurse remembered that in the beginnings they were more and “covered more aspects.” Similarly, Sánchez told me that “in 10-15 years we have not had new personnel. The plan is, I suppose, that we get old and it all ends.”

Their initial work related to care and rehabilitation has been cut back over the years. A psychiatrist from the division commented that home interventions, which served to avoid hospitalisations, are no longer a part of their repertoire:

We had cars and walkie-talkies. If there was someone suffering a crisis, all of the team would go and do crisis intervention. A bit like the model in England, in Europe, in other countries. That does not happen anymore. If someone is in crisis, we do family intervention; we talk them into taking the person to the Emergency Department.

Sánchez said their job became stigmatised and they were told to shift their focus onto promotion and prevention activities (“let’s do health promotion, that’s the boom, the future”). She continued to tell me about the remainders of their old work:

There was a social skills training workshop in the health centre, managed by a psychologist. That is not there anymore. We only have the psychosocial clubs left, managed by us, the nurses. I am realising that we, as a profession, are very resilient and persistent.

I found four critiques made to the work of the Division of Collective Health. The first one is related to the early conversion of Noguchi from community centre to institute. In 1980, their aim was to alleviate some of the existent patient demand by working within seven primary health centres and they planned to increase their scope progressively throughout the northern part of Lima. In 1981, however, under the new investiture, the

priority of the national institute became research, triggering a new identity as researchers and obscuring the task of healthcare delivery. This, of course, did not favour the initial plans of the Department of Community Mental Health.

The second critique, this time within the sphere of health care delivery, was linked to Noguchi's specialised status within the public health system. Being at the top of the ladder, they are supposed to focus on the most severe mental health issues. Based on this presupposition, the division's primary healthcare inclinations were seen as misguided. They should not become a part of the decentralised health centres, it was argued, but instead assert their condition of experts by providing specialised support.

The third tension springs out from the expansionist drive that is rooted in the public health imperative of providing health care for all. The coverage of the division has been small, it has failed to branch out and satisfy a larger public demand. It is worth noting that the will to expand has not been absent, but has failed. There was an effort to train health care personnel from the primary care centres and advance their work throughout the northern part of Lima, but this was curtailed in the 1990s by the department's involvement in the National Mental Health Programme. Additionally, the training established in the first decade of the new century, after their involvement in national policy was over, is reported as ineffective.

The fourth critique I came across was related to this last aspect, the fact that they have not been able to get primary health care personnel to deal with mental health issues. A young psychiatrist from the division, who had recently arrived with the creation of Project Apurímac, argued that this should be the case:

If a general doctor can manage the treatment of a hypertensive person, which is somewhat complicated, and the complications and medical interactions of an anticonvulsant, why can't he handle an antidepressant, which has less drug interactions and is easier to use? But our consultation room in the centre is like an island of the institute. While in the rest of the health centre a model of integral care is in place, the mental health service remains disconnected.

In the centre she visited once a week, health personnel excluded mental health issues from their work and just referred them to the Noguchi staff. This, she contends, reinforces the unfamiliarity and stigma towards mental health within primary care.

In the following section I will explore the perspective of community mental health workers; the way in which they conceive the psychiatric endeavour in the face of critique, scepticism, and waning resources.

## An Ethics of Care

Dr Flores was part of the foundational generation of Instituto Noguchi psychiatrists. When he finished his residency, he was called up by Castro de la Mata to work in the community service centre that had been set up in 1980. A year later, the institute was established.

Flores' response when I asked him to describe his work in the division revealed his orientation:

We work close to the home and the community. This has led us to take a set of actions that allow an interrelationship with the community. We do open groups. The traditional way is that the doctor carries out a consultation. But before that, we came up with this many years ago, we should interact with people. The meetings we have allow the people to feel more comfortable. We talk about topics such as depression, suicide, emotional problems; but we also tell them that it serves the purpose of building rapport among us. We think that this lightens the consultation a lot. It is as if someone who goes to a consultation wants to know the doctor first. And this getting-to-know-you phase does not appear again in the consultation. There are also other factors that contribute to their feelings of trust. We know, for example, that there is a community organisation where people tell others that we provide a good service.

The importance given to their relationship with the people who arrive at their service and the need to make them feel at ease was also brought up by nurse Sánchez, who mentioned this was key in order to achieve an ongoing relationship.

Another positive quality of their service was that, even though they were overloaded with demand, they scheduled appointments every week or 15 days. They were able to do this, possibly, by taking their service capacity to the limit. Flores talked about seeing an elevated amount of patients:

Some colleagues attack us saying: "your work is second quality", "why don't you dedicate more time to the patient?", "how can someone possibly see 15 or 20 patients in a single morning?" Look at this (he says while grabbing a patient register from the desk of the Noguchi consultation room where we were talking).

In this service they see three or six patients each day. In the community centre you have to be more agile. People demand this, it is not nonsense. But this is not understood by the other psychiatrists. For example, they would never understand what a Japanese colleague told me: “Dr Flores, would you believe that psychiatrists from my clinic see 50 patients per day?”

An attribute that is usually linked to low quality of care, spending a small amount of time with the patient, is posited by Flores as the right thing to do in a context where there is an excessive demand of patients. He argues that the critique made by psychiatrists from the institute is out of touch with this reality.

Another trait that stood out from Flores’ discourse was his repeated reference to the importance of taking people’s views into account. He talked about the need of valuing how patients regard and live with their own problems, and related this aspect to the social sciences:

Sociologists and anthropologists are important. We do not have them within our reach though. We have, many times, scratched methodological aspects of these disciplines, but we do not know them that well. Their contribution would make research richer, more agile, and easier.

I found a similar disposition in nurse Sanchez’ definition of the term psychoeducation, which until then I had perceived as an activity whereby patients and their families are taught about their mental health conditions and how to manage them. Sánchez’s notion, however, was more participatory:

We do psychoeducation, we talk with them. It is not an educational talk, but an exploration. We ask them to share with us what they think, what they feel about being sick or it means to be depressed. Some are treated by their husbands as crazy. So having a diagnosis carries all these perceptions, all these meanings, for them and their families. We also talk about what is happening with the medicines. Dependency is something that worries them a lot and we discuss it.

This attentiveness towards lay perspectives of mental health is something that psychiatrists lack, according to Flores, who defines them as self-absorbed:

Psychiatrists are weird. They think that the couch or the beard makes them seem scientific or technical, of great importance, and that the patient will believe in them because of this. They say: “Why should I be interested in people’s beliefs. I

have my psychoanalytic scheme, cognitive behavioural therapy, my clinical way, and the patient will benefit from me.”

All in all, these ideas and practices represent a specific ethical paradigm of care that has its roots in Castro de la Mata’s initial enterprise in northern Lima. Working within the community, building trusting relationships, the imperative to meet as many patient demands as possible, and legitimising people’s own categories and modes of thought, are all markers of a psychiatric identity that, for some, is used as a source of differentiation from the standard moral economy of care within the institute.

### Life Beyond the Hospital: The Work of Nurses and Social Workers

Abandonment is a common scenario that people with schizophrenia have to endure. Most of the patients from the chronic cohort at Hospital Valdezán’s community centre, for example, did not have family. Years go by and the person does not get better. Families get tired of the situation and lose faith in the individual’s recovery. Some go as far as hitting their sick family member, while others tie them up or lock them up in a room. In many cases, mothers are the caregivers (siblings tend to get married and leave home) and when they get sick or die, patients are left by themselves. Some of them live on the streets and some remain in their houses without receiving any support, living in their “schizophrenic worlds”. Others receive money allowances from family members who live separately, but these are rarely enough for them to cover their basic needs.

At least this is the way in which nurses and social workers from the community mental health areas of the hospitals described the social situation of patients with schizophrenia. Given their proximity to patients and families, they were the ones more acquainted with the complex social dynamics that surround mental illness. In general terms, psychiatrists and psychologists see patients less frequently and focus mostly on individual consultations. At Noguchi’s Division of Collective Health, for instance, psychiatrists meet patients roughly once every two months in order to evaluate their symptomatology and adjust their psychopharmacological scheme accordingly. Although some may listen to their patients’ broader life struggles, their intervention in that regard is limited to providing advice or delegating to nurses and social workers.



The bulk of rehabilitation activities and ensuring patients follow their treatment and recover as smoothly as possible is the job of the nurses and social workers. Both the Noguchi and Valdizán teams engaged in weekly sessions with groups of chronic patients. They trained them in tasks of daily living and taught them how to make handicrafts they could sell, as well as holding different recreational activities in order for patients to socialise between each other. Fund-raising events were also occasionally arranged.

The work of nurses and social workers frame “communities as sites of local problem-solving”, which involve “thinking beyond the management of cases to getting medicine to individuals having real-world constraints...” (Nichter, 2008, p. 123). The Valdizán team, for example, held a weekly meeting with the psychosis group, where each person talked about how they had been doing in the past week. This gave them the opportunity to swiftly identify problems and think about solutions.

One of their basic roles was to make sure that patients followed through with the psychopharmacological treatment prescribed by psychiatrists. If patients missed consultations or group meetings, they visited them in order to find out what the problem was. Family relations would be leveraged in favour of treatment compliance, or medicine discounts would be made to families that did not have enough money to buy them. Psychopharmaceuticals are a thorny issue. They have to explain why they are taking them, assure them that they do not create dependency, and talk about side effects and the precautions they should take.

Another domain of intervention were personal relationships, be it within the sphere of the family or elsewhere. If family members were troubling the patient in any way, or if they did not support him or her enough, nurses would try and make them change their family dynamics. They also had support groups for women who suffered from domestic violence and special assistance, such as looking for women’s shelters, would be provided for those in need.

Furthermore, some patients had basic needs problems related to housing and food procurement. Issues of housing were explained by a social worker:

Our patients own land lots but they have lost many opportunities. For example, the bonds for house owners, nobody told them about that. We are always telling the community’s central committee that they exclude the neighbours who are more needful than them. We want them to take advantage of these bonds. And

there are other problems. They have a property title and there are family members who want to take advantage of that property. There is one family member who is making loans with a property title for his personal gain. He is making our patient lose the chance of getting the house owner bond. Then, there is a case where the niece has the property title and she is starting to build. The patient is over 50 years old. We have to see what plans they have for him. Out of 18 patients, six are land lot owners. They only have wooden shacks without basic services. They have to ask others for water. They have plenty of difficulties.

When patients were living in vulnerable conditions that exposed them to health hazards, resources for improving their houses were sought within community and institutional networks.

Regarding food procurement, the regular solution was to ask local community kitchens to serve them for free. A nurse told me about a case in which this type of arrangement failed and how they found a new solution:

We have a patient who is calmed, communicative, and accessible. In general, when stable he is cheerful. One day we saw him crestfallen, quiet, he seemed to be worried. We asked him what was happening and he told us he had missed lunch for the past 15 days. We asked why he had not said anything. He was ashamed and did not want to bother us. We found out that the community kitchen had taken back their help because their budget had been curtailed. So our social service had to look for another network of support. He works watering the yards of a school that is managed by a nun. The social worker talked with her and she agreed to help him. Now he takes a bowl and they give him lunch and dinner, so he can take it home and heat up the food.

A job contributes to the goals of economic independence and social reintegration. When María (a psychiatrist from Hospital Valdizán) joined one group session, she expressed surprise over the level of independence that some of the patients had reached: “You work, you support yourselves. You do not look like people with mental health problems.”

Nurses and social workers encouraged patients to look for work in areas such as recycling, cleaning, gardening, or street vending, and sought to connect them with persons or institutions that were willing to offer opportunities. If there were problems, due to the stigma attached to mental illness or for other reasons, they would have a talk with the employer and assure them that the person was “stable” and following treatment. They also had in mind potential negative effects that jobs could have on patients. They evaluated their aptness for work and what type of job would suit them

best. If a patient was prone to suffering a breakdown, or if working conditions were too stressful, then their enrolment would be reconsidered.

One social worker defined her role as being the link between patients and the community and institutions. As I have described, part of their methodology was to detect problems and look for support at different levels of the social network—families, communities, and institutions. They also strived to make patient and family groups participate in community networks where they could make their issues and progress visible. In this way, communities opened up to a topic that carried the weight of deep-seated stigma.

In the institutional realm, nurses and social workers carried out a myriad of tasks. They looked for activities of other mental health and disability-related institutions that patients could join; they checked if someone did not have identity documents or was not affiliated to health insurance plans; they helped users and families in their interactions with health services when needed; and they made sure that every chronic patient had a national disability card that awarded them benefits for entertainment activities and job opportunities offered by local municipalities. This support was moral as much as practical: patients felt empowered by their disability card and the privileged accesses it granted them.

Social workers also went beyond the scope of individual case problem-solving. The Noguchi team promoted the collective organisation of the families of persons with chronic mental health ailments. These groups, based in the primary health care centres, had boards of directors and were legally recognised by local municipalities. This gave them the chance to participate in local government activities such as participatory budgeting, where mental health problems could be made visible to authorities.

In 2007, the two family groups from San Martín de Porres joined forces, as well as with several other disability organisations—this probably strengthened their position because these groups are more experienced and have stronger leadership—in order to successfully pursue the development of a sports complex for people with disabilities in the local participatory budget. At the time of my fieldwork, they were trying to push the creation of a residential facility for the homeless mentally ill. They asked the Municipality to provide a house for this project, but after one year there were no results, so they themselves began to search for abandoned houses or lots of land that could be included in their project proposal.

As I have reviewed, nurses and social workers practice a close and ongoing monitoring of patients with chronic ailments in the community mental health programmes. As a Valdizán nurse told me: “We have a lot of contact with our patients. We see them two or three times during the week. Thus, we know what they are doing, how they are, what difficulties they have. We try to stay vigilant most of the time”. Some of the patients would hang around at Valdizán’s community centre at times where there were no programmed group activities, sitting with us and occasionally talking to someone. “It is a place where we welcome them. They are with us, they spend a lot of time here, they feel at home,” a social worker pointed out. The relationships cultivated among patients and staff grow inevitably intimate, and the latter know at any point in time what the state of their personal hygiene is, if someone is attending an IT course, or who is working and who is not.

A Noguchi social worker who was based at two primary health care centres told me that her work was quite demanding and that it defied the regular parameters of a nine-to-five job:

The participatory budgeting meetings can be set at any time and day. They can be on a Saturday or Sunday, at night, morning, or in the afternoon. This is not in accordance with our own fixed work schedule. But I would participate, anyways. I remember that we filled the required paperwork at nights. Generally, we end up working at home, it interferes with our families.

Given the lack of support from the institute, she often had to use her own money to pay for expenses such as transport, office supplies, printing, and the production of educational material. She also made a “collaboration” to the family organisations when they had to pay for registering with the municipality. This kind of onerous work is fuelled by their closeness to the community, which engenders a sense of heightened commitment and prevents them from quitting. In the words of the same social worker: “I have thought about quitting or changing jobs. This work is beautiful, we love it. And well, we keep on going because of the mystique of the task.”

The work of nurses and social workers can be seen as unreflective and apolitical in a way. They are not thinking about politics as an abstract critique of the status quo or as broad projects of reform, nor as participation in formal politics. In other words, they are not thinking about large-scale politics. But they do practice politics, a kind of localised

partisan politics. It is within the small scale of the community that they strive to change the lives of people suffering from mental health problems and it is the grounded concerns of these people and their families that guide them in their endeavours of social therapy.

I was surprised when I learned about the work these professions do in detail. Given the comprehensive character of their work, which covers a varied number of dimensions in people's lives, and the great impact it seems to have on the recovery of patients, why is there not more buzz surrounding them? Why is there not more research focused, within the hospital, in their areas of work? Why do they not hold more power in the field of mental health?

### Dr Quispe and the New Agenda

As it had happened in the 1990s, when personnel of the Department of Community Mental Health were in charge of the National Mental Health Programme, Project Apurímac reduced the time available for community mental health activities. As a result, those who were entirely dedicated to this task opposed the new initiative that had been brought by someone from outside of the division (Dr Quispe). They thought it was wrong to retreat from the community and leave people's needs unattended. The new agenda jeopardised the imperative to intervene upon those needs and perform care as community health workers.

Nurse Sánchez had also worked in the community mental health realm since the beginning and valued what had been achieved over the years. She had, however, a different stance. The work of the division, she thought, had served to strengthen their expertise, which has been of use for the development of national policy documents in the past and for the implementation of Project Apurímac in the present. In the case of the division, their familiarity with the primary health care work environment stood out when compared to colleagues who had worked exclusively within the institute and were detached from that reality. Thus, the value of their work went beyond the virtues of the community programme per se and resided in the potential reproduction of their expertise in other spaces: "It is not about us, it is about transcending. A programme transcends when it is transferred to other places, when there is more personnel working on it, when you have documents that can guide others," she alleged.

I met Dr Quispe in his office within the division on a Thursday morning, before the start of his workday. He had promptly agreed to meet with me a week before over the phone. He struck me as a smart and friendly person who was quite enthusiastic about the Apurímac project. When I was heading off through the hallway of the division after this first encounter, he came out of his office and called me back again. He handed me a manila envelope that contained Project Apurímac's initial proposal, an annual report, and a fancy brochure with general information about the project.

He had been appointed head of the division four years before, coming from the Division of Children and Adolescents. Within the division, he was solely focused on Project Apurímac, unlike the other psychiatrists of the division who, to differing degrees, also performed patient work at the adjacent primary care centres. But he did provide care in his private practice, where he was specialised in child psychiatry and family therapy. "My approach is predominantly systemic. The nature of our work here pushes us towards a social, systemic vision," he reflected. He worked with a team of psychologists in people's homes, rather than in a consultation room, and focused "on people's problems and the dynamics that surround them, and on the joint elaboration of solutions, taking their contextual resources into account". He distinguished this perspective from the "clinical paradigm" focused on mental disorders and the prescription of psychopharmaceuticals: "We focus on biology because we have the medicines on hand," he argued.

Quispe, then, presented himself as a psychiatrist who views and performs his craft differently to how it is usually done by other practitioners. He, too, had a critical stance towards how the discipline is practiced within the hospital: "Here we are comfortably locked in, as I tell my colleagues, with our nails neatly cut, without claws." He used this metaphor to depict their unwillingness to engage with the realities of public health services beyond the institute.

Even though he was a stranger to the division when he arrived, nurse Sánchez approved of Quispe's appointment:

This time the appointed chief was not one of us, but one of them. I think he has set a bridge of communication. He has probably found that we were not as bad as they thought, and we also have seen that the guys from the inside were not as bad as we thought. Now there is a synergy of efforts, we complement each other.

Thus, his designation by the institute's management served to advance the integration of an area that had previously been somewhat isolated, and it also allowed the channelling of the division's expertise into a new public health agenda of services reform.

The change in name of the division from community mental health to collective health appears to have been related to this change in focus from being a localised programme to addressing wider public health matters. Dr Flores told me that he perceived this modification as an attempt to forget their community mental health historical tradition.

Service reform plans were linked to the epidemiological endeavours in which Noguchi's Research Department had been involved with since 2002. Led by the psychiatrist who was head of that department, these epidemiological studies have mapped the national prevalence rates of mental health problems. The first one was based in Lima and, in the following decade, studies covering urban and rural areas of several regions of the country were published. In 2010, the research and service reform agendas were coupled when the epidemiological study of Apurímac's capital served as a baseline for the implementation of Project Apurímac. Dr Quispe, who had been involved in the epidemiological studies before arriving at Collective Health, referred to the necessity of developing intervention work: "The table only had two legs, research was not giving concrete products". This new applied undertaking enhanced Noguchi's role as national institute from the production of expertise and policy recommendations to the direct intervention in the organisation of the public health system, a task otherwise carried out by the Ministry of Health's central offices.

Alongside Quispe, two young practitioners, self-proclaimed public health psychiatrists, were brought to the division for Project Apurímac. In addition to this, residents were included in the training sessions and team meetings of the project so they could get the feel of carrying out this alternative kind of psychiatric work. Furthermore, a specific lexicon was used to posit the service reform agenda as an improvement for the division. Scale of intervention was stressed as an issue of great importance. Dr Quispe, for example, argued that, as the city has grown a lot throughout the years, the original scale of the community mental health programme has fallen short of satisfying demand for services.

The new agenda had a “bigger and more extensive logic” and a “regional orientation” rather than a local one. When I asked one of the young psychiatrists from the division about their work in the nearby health centres, she clarified that their present role is broader than that:

This is not the only dimension, because you could think that community psychiatry is seeing patients in the community. No, we operate as an institute. The Division of Collective Health is working in the project of public mental health, let us call community projects like this. We are doing a national intervention, an important project in Apurímac. We are giving technical advice to residential care homes in Iquitos. This is going to be implemented in Lima also. I do not know if I am being clear here. The scope of this is vast.

By describing the new agenda as a public health approach, in comparison to the traditional work done by the division, psychiatrists implied that community mental health was not a public health matter. Under this definition, the field of public health is inherently a large scale enterprise concerning the universalisation of services. Project Apurímac was the first step towards the greater aim of advancing mental health services in the whole nation.

### Project Apurímac

My account and thoughts on Project Apurímac are based on interviews with Dr Quispe, several other psychiatric and non-psychiatric members of the project team, and psychiatrists from other areas of the institute, as well as the project's initial written outline (INSM HD-HN, 2010). All of this data was collected in Lima, within the premises of the Division of Collective Health or in the offices of other practitioners. I did not go to Apurímac to witness the implementation of the project in situ because I was not allowed to follow the institute's personnel during their daily work. In terms of what was actually happening with the implementation of the project, then, I could not complement the second-hand information gathered with direct observation of events in Apurímac.

Apurímac is an Andean region made up of seven provinces and inhabited by 400,000 people. Mental health services were largely absent in the region before the arrival of the project. In terms of general health services, there is an adequate number of primary care centres, but doctors are lacking. The decentralisation of services here is



an especially significant issue due to the isolation of many of its populated areas, where transportation is problematic.

The aim of Project Apurímac was to generate mental health services within the general health system of the region through training personnel from primary care centres and hospitals. Doctors, obstetricians, nurses, and psychologists received theoretical training in their workplaces and were subsequently supervised and guided in their day-to-day practice. The main mental health problems tackled were depression and suicidal conduct, psychosis, family violence, alcohol abuse, and child sexual abuse.

The institute chose Apurímac as a site of intervention due to its high levels of poverty and also because there was a dearth of humanitarian projects in the region. Its ambitious scope and the geographic isolation of Apurímac made the project a strenuous one, implying the mobilisation of numerous staff from other Noguchi divisions that helped in the training of more than 500 health professionals in every province of the region. A psychiatrist from the Research Department shared his concern about the remoteness of Apurímac:

As a pilot project, it went a thousand kilometres south. There are issues of communication. Our colleagues travel two days and work two days. It is not feasible, then, to make changes along the way, the process is too long. I told them they could have done a pilot project in the highlands of Lima and then progressively move on to other parts. But not in a steep, geographically isolated area.

One of the project's policy documents states the existence of personal, institutional and structural stigmas towards mental health. These sources of exclusion are reflected in the unwillingness of health personnel to pay attention to this dimension in their practice, as well as in university curricula, where the mental health item is isolated from other topics and not included in internship programmes. Stigma, as reported by psychiatrists in the field, goes as far as health personnel from general hospitals not wanting to receive psychiatric patients for a medical emergency. Or the case of a hospital where the psychiatric ward was set in a precarious separate facility that was in danger of collapsing.<sup>19</sup>

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<sup>19</sup> The national Ombudsman's Office sued the hospital for this reason and patients were eventually transferred to a new building on the outskirts of the city. Although an improvement,

The project team in Apurímac found that mental health tasks within primary care establishments were exclusively performed by psychologists, if they were available. This was so because the other personnel avoided them, or due to psychologists themselves not wanting to share their area of intervention. Mental health was further impaired by strong health sector programmes that diverted its scarce resources, as nurse Sánchez told me:

I looked for the psychologist and where was he? In the immunisation campaign. I would ask him: “Why don’t you organise therapy groups?” “Because I have things to do outside.” “What do you do in the immunisation programme?” “Register people.” I found this surprising. These administration programmes have a large budget, so they pay you extra if you participate. This is not the case with mental health, which was not even covered by the national health insurance plan.

The intention of the project was to spread out simpler mental health tasks—detection and basic treatment—to other actors—doctors, nurses, and obstetricians—and to encourage psychologists to develop therapeutic practices and programmes for more complex problems. For the non-specialised professionals, this entailed the expansion of a strictly physical perspective on the patient to one that takes his or her emotional and relational dimensions into account. This, according to nurse Sánchez, is not a matter of dedicating more time to these new duties, but of developing an added sensibility within the same activities performed by each professional. Obstetricians can detect physical signs of violence during prenatal examinations, nurses can think about the emotional state and family relations of the children who are seen in the growth and development programme, and suicidal thoughts and alcohol abuse can be sought for in the case of TB patients.

The division had already experienced the advancement of mental health within primary care establishments in their work in Lima, as Sánchez expressed in the following quote:

When our work started, talking about mental health was almost esoteric. Nurses talking about mental health in a primary care centre was unprecedented, it was perceived as strange. But they have gradually improved, acquiring their own personnel. Also, people with psychosis can be treated in a health centre now.

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this new marginal location and the form of institutional care provided there was considered as retrograde by psychiatrists.

Before they used to say: “Get your patients out of here, they make the establishment look bad.” Now no one dares to say that. They receive and support them, from the moment they get to admissions.

Based on their past experiences, they had devised strategies that enhanced the effectiveness of their relationship with health personnel. For example, they learned that talking about the staff’s own emotional problems helped portray mental health issues in a familiar light, having a positive effect on their attitude towards them. Another innovation was born from their realisation that training auxiliary nurses separately from nurses and letting them know that their work is important generates a greater deal of enthusiasm in them.

In recent years, just before the launch of Project Apurímac, the division had applied a training programme in Lima that did not produce the desired results. This had generated a natural scepticism within the institute towards these sorts of initiatives. From this experience they learned that issues such as high labour mobility and shortage of resources and infrastructure in primary care hampered the impact that training has on the actual implementation of mental health services. Thus, more had to be done for the advancement of mental health to succeed.

Bearing this in mind, the financial collaboration of the Ministry of Health and of the Regional Government of Apurímac, which also created a Regional Mental Health Plan, was achieved through advocacy work. Dr Quispe seemed to be quite devoted to this type of work, as he was frequently absent from the division, sometimes visiting the Ministry of Health. In addition to this, a cooperation agreement was signed with the German Agency for International Cooperation (GIZ). The project team wanted them to fund a regional awareness-raising event for mayors, while the Germans were interested in addressing violence against women. Key goals for the future sustainability of the project were funding new infrastructure—for example, mental health consultation rooms, group therapy rooms, and hospital beds—and personnel by the regional government<sup>20</sup>, and the creation of mental health guidelines by regional health authorities and their inclusion in the operational plans of health establishments.

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<sup>20</sup> In 2002, the Peruvian government initiated a political decentralisation process, transforming the country’s different states into “regions” with the autonomy to decide on their own fate in a variety of matters. They were handed the authority to assume the control of regional health authorities and organise their own health systems. For this reason, it was key to achieve the collaboration of the regional government.

According to Dr Quispe, a significant number of maternal suicide cases that happened at the same period of time were critical in sparking the interest of regional authorities in the development of mental health services:

The circumstances helped us a lot. Before starting the training programme, there was a downpour of suicide cases of pregnant women. In four months, four pregnant women that had been in the health centres days before committed suicide. They all even had ultrasounds—because now health centres are well implemented for the physical control of pregnant women. But this helped because it mobilised the personnel and health authorities, who have invested funds to decrease maternal mortality in the region. We have not needed to raise awareness because they were hit by reality. It happened in four different places, almost as if it were planned. And that allowed for overcoming the stigma associated with mental health services.

As Quispe emphasises, it is telling that an issue that carries more epidemiological and political value such as maternal mortality would attract the attention of authorities towards mental health, an otherwise overlooked domain.

Finally, some features of the project sought to overcome the problems generated by the unstable nature of labour in regional health offices and establishments by institutionalising the training component within these settings. In this regard, the project considered establishing a number of training centres where regional personnel could themselves apply the training guidelines that had been elaborated.

## Discussion

In this chapter my intent has been to compare two different paradigms of psychiatry that emerged in juxtaposition during my fieldwork at Noguchi's Division of Collective Health. The first one, community mental health, has been depicted in the early history of the department and in the present work of nurses and social workers, while the mental health services reform agenda has been represented by the description of Project Apurímac. Here I want to outline the implications of the nascent predominance of the latter model.

The newly arrived service reform agenda was an attempt to redefine the role of the traditional community mental health department. The advancement of mental health services in unattended areas has been justified by the use of a psychiatric rhetoric of

ethical urgency. Dr Quispe, for instance, expressed a sense of imperativeness and defined the development of national mental health services as “an ethical matter”. Apurímac’s Andean cities and communities are seen through the lens of psychiatry: people are suffering from depression, anxiety, post-traumatic stress disorder, or schizophrenia. This rhetoric is legitimised by the epidemiological study carried out in one city of the region, which shows that these mental disorders are in fact there. In this way, as Nichter states, “public health rhetoric uses representations to frame problems and populations in ways that render particular types of solutions compelling and worthy of research and funding” (2008, p. 106). In other words, psychiatric labeling allows psychiatric intervention to be seen as the appropriate solution.

Project Apurímac had garnered more resources and the Noguchi team had much more experience in community mental health than its Valdizán counterpart, thus making this endeavour more successful comparatively. Within its defined scope of action, after two years of its implementation, the project was obtaining positive results. Psychiatric services were set up in two hospitals, psychopharmaceuticals were introduced, and primary health care personnel were accepting the newly proposed mental health roles.

Viewed from a broader angle, however, the project is missing the comprehensive approach championed by Castro de la Mata. The main aim of the project was the implementation of services, and that is what is more likely to be achieved. This constitutes a narrow recuperative approach that relegates other aspects of community mental health such as rehabilitation, preventive and promotional practices, and intersectoral coordination. A view that reduces mental health outcomes to universal access to treatment. Good and Good (2012, p. 175) and Varma (2016), for instance, mention how global mental health programmes risk focusing on acute services while neglecting chronic care and rehabilitation.

Furthermore, while the new agenda was centred on implementing a mental health services reform, Castro de la Mata and his community mental health cohort focused as well on ways of improving psychiatric treatment. The psychiatric style they sought to implement is something to be valued in the efforts to effectively cover the treatment gap. Taking people’s own perspectives into account, developing locally relevant approaches, and cultivating closeness with patients and their families might go a long way in rural contexts where cultural differences between the population and urban health personnel are particularly acute.

The large-scale mental health services reform enterprise of Project Apurímac overlooks local contingencies by mainly focusing on the implementation of treatment for a limited number of mental health problems as defined by an urban-based team without any previous experience with communities from the Peruvian Southern Andes. Summerfield (2008; 2012) has critiqued this kind of imposition of foreign ideologies and treatments by psychiatry and the Global Mental Health enterprise in the name of education and development. He argues that Western psychiatric research and services are culture-specific entities that cannot be validly exported to any part of the world (Summerfield, 2008, p. 992). Instead of treating local forms of distress as second-rate knowledge (Summerfield, 2012, p. 525), the agenda should veer towards a bottom-up approach that researches local concepts in order to inform the creation of new contextually-sensitive screening and diagnosis instruments and public health policy more generally (Summerfield, 2012, p. 528).

I will now review two examples from anthropological literature, based on two areas that are culturally similar to Apurímac, that illustrate how the extension of mental health services to the population is mediated by local culture, socioeconomic condition, and history. Ignoring this presents a number of practical difficulties that can render mental health services ineffective.

Given that “similar complaints may appear in different cultural groups, but having different meanings and attributions of causality and distinct symbolic values” (Pedersen, 2010, p. 280), there is a risk of diagnosing problems in an ethnocentric manner. On the one hand, practitioners may misrepresent a local idiom of distress as one of the symptoms that indicate a psychiatric diagnostic category. On the other hand, aspects that hold an important position in local representations of sociality and suffering may remain ignored by health personnel. Orr (2013) reports that such is the case in Cuzco, a region contiguous to Apurímac, where refusing to eat is afforded critical local importance as an index of personal and interpersonal problems. However, practitioners at primary health care centres and at one community mental health service do not pay attention to these complaints and instead focus on those sanctioned by psychiatry.

Furthermore, studying local treatment decision-making is another necessary component for the implementation of services. In another article based on a village in Cuzco, Orr (2012) explains why traditional healers remain more popular than mental health services with the locals. He observed a “therapeutic impatience” in families: they

expect therapy to take effect, or not, in the short term and, consequently, do not visit the same healer more than once. This concept of recovery is based on specific etiological models of disease that relate recovery to specific events such as the soul re-entering the body in soul loss. The healer either achieves this or not. In the case of biomedicine, the standardisation of its practice determines that every practitioner is seen as giving out the same service, there is no difference between one and another, and so it does not make sense to consult more than one doctor. On the other hand, traditional healers lack a systematised medical framework. Their work is based on differentiating themselves so that they are seen as better than the other. As a result of this, people remain hopeful that the next healer will achieve success.

Pedersen (2010), for his part, argues that emotional configurations and expressions of distress are locally specific in an article set in Ayacucho, another Southern Andean region. His research team proved that people in the Southern Andes use their own language of distress:

We further tried eliciting emotions and similar experiences of distress and suffering with terms and expressions of common usage among us, such as “stressful,” “being anxious,” “being under pressure” or “being tense like the cords of the violin.” However, our informants did not recognise “stressful,” “anxious” or “being tense” as existing conditions among them; nor do they have equivalent words in the Quechua language. They preferred to use instead their own metaphor, “being like palo seco,” alluding to the fragile state of a dry wooden stick, fracturing easily under the slightest pressure (Pedersen, 2010, p. 289).

He sets out to describe the semantic network of associations that provides meaning to idioms of distress and symptomatic expressions. Distress related to *llaki* (sorrow) and *ñakary* (suffering) is expressed through a diversity of somatic pains.

Moreover, expressions of suffering are mediated by history and social situation, the author adds. Local idioms of distress were linked to memories of the “difficult times”, a reference to the historical moment when these communities were stuck in between the fight of the Maoist guerrilla group Shining Path and the military. These traumatic events had significant material consequences, impoverishing the lives of many. Consequently, narratives of suffering are also generally linked to the socially precarious conditions under which people were left to live.

Project Apurímac may well reach an optimal level of success in its goal of

implementing mental health services in the public health system if it continues the work it has done so far. I suggest, however, that the goal should be expanded to the population's use of these services and the impact that they have on collective well-being. Without taking local context into account, the project may not be as successful in this regard.





## The Outpatient Area

I was sitting in the outdoor waiting space of the outpatient area in Hospital Valdizán, along with many patients and their families, waiting for one of the psychiatrists to call me into his office. Approximately 50 people could fit in that space. To my left I saw a large sign that said: “Agusto gives you a better service. Our renovated offices make your wait more pleasant.” Agusto, a male cartoon figure, was the mascot of the campaign the hospital’s administration had designed to champion the improvement of patient service. These efforts included refurbishing the outpatient area, which was made more comfortable for patients. They installed television screens that continually displayed a Scandinavian hidden camera show, mimicking the waiting area of Lima’s banks, and each attending psychiatrist’s patient list.

It was one of several days in which I joined psychiatrists in their morning or afternoon shifts in the outpatient area of Hospital Valdizán. The waiting space was usually packed with attendees because Hospital Valdizán was notably overburdened by patient demand. Consultations ran from 8am to 8pm. People arrived at the area at six in the morning and frequently expressed frustration when they had to wait for a long time. The number of patients seen in daily shifts varied among practitioners. Some, compelled by the great demand expressed outside their offices, would see up to 20 patients per shift, surpassing the amount of time they were supposed to stay at the hospital. Others stayed within the confines of what they considered rational or within the time limits of their schedule. One of these psychiatrists argued that he limited himself to seeing twelve patients per shift because he would otherwise turn into an automaton. He chose quality over quantity. Indeed, one of the practitioners who saw more patients admitted to me that she would become increasingly tired as the shift went on. However, she—and others like her—chose to forgo the best possible standard of care in order to respond to existing patient demand.

As a result of the extensive waiting list of the outpatient area, psychiatrists cannot

make appointments with the frequency they would like to. I asked one of them, after a consultation, about the appointment he had just made and he showed me the availability of dates on his desk's computer screen. "Ideally, I would give him meds and tell him to come back in two weeks, but it can't be done. I have to tell him that if he relapses, he can come in through the emergency unit," he replied. In the consultations I observed, appointments were usually scheduled every two or three months.

In terms of the time given to patients in consultations, every psychiatrist from Hospital Valdizán I talked to said it was limited. One of them did not feel comfortable, at first, with me observing him operate under these substandard conditions, although he eventually loosened up. They compared this with the conditions they work under in their private practices: "It is much better; you have your own schedule. You have time for treating each patient and you can do it as you wish. Here you have to do it fast. You would like to say more but you have all these people waiting, you just can't. Sometimes you don't finish," one of them said. This situation turned the public hospital into a recruitment ground for private practice. If the patient can afford to pay a higher price, then he can be guided towards private practice, where he will be given more time and better treatment overall.

Consultations at the outpatient area can be divided into two types, new and continuing patients. A shift would typically include two new ones and the rest would be continuing patients. The former demand more time because the psychiatrist has to write up a new patient history and arrive at a diagnosis, while the latter can be dealt with in shorter follow-up sessions where the doctor can adjust treatment according to how the patient is doing. In general, practitioners said that new patients should take between forty minutes and an hour, and continuing patients twenty or thirty minutes, unless the psychiatrist engages in prolonged psychotherapy. What I found in the three practitioners I observed in the outpatient area ranged, in average, from thirteen to twenty minutes per consultation.

Thus, in the public hospital the construction of the patient's case and psychotherapy becomes sacrificed. For example, when comparing the duration of one of María's consultations at Hospital Valdizán with the ones she did at the community centre in Huaycán (chapter three), a big difference was revealed: on average, eighteen minutes against forty-eight. This difference was shorter, however, in other practitioners whose consultations at Huaycán were only five minutes longer than the ones of Hospital

Valdizán. For psychiatrists not engaging in psychotherapies of any kind, follow-up visits will last a similar amount of time in both constrained and non-constrained contexts. María referred to these shorter follow-up visits as “light consultations”. “It’s not a matter of saying: ‘All good? All good, fine. Keep taking your pill,’ she criticised.

If we view mental illness as having a life cycle, the central focus of treatment in outpatient consultations is the moment of stability. The patient may either be moving towards stability, may have achieved stability, or may be moving away from this state. Psychiatrist’s job is to aid him in this process by adjusting his medicines and referring him to other services. If the patient gets too far away from stability, then he will be hospitalised. The more stable he gets, the simpler the doctor visits become. In one consultation, a practitioner from Hospital Valdizán told the patient to keep taking her “maintenance dose” of medication and that her visit was more a “courtesy call” than a real medical check-up. Patient follow-up can even be done by over the phone. I witnessed psychiatrists receiving quick calls from patients and giving out indications, including medicine adjustments.

Following up the patient is what distinguishes outpatient treatment from hospitalisation wards. A Noguchi psychiatrist from the outpatient area commented that this was one of the reasons he liked the job:

You can see the patient from the beginning, when he arrives, and see how he progresses and how to make adjustments. You follow them, if they keep coming. Most of them do. You adjust appointments and pharmacology according to the patient’s clinical condition. Finally, you can achieve improvement.

This extended form of care is not present in emergency or inpatient treatment, where psychiatrists focus on a single critical time frame within the patient’s illness and, after that, may never see him again. In this practitioner’s words, we can also get a sense of having more control over the therapeutic process. He is able to make adjustments and ultimately improve the patient’s illness course. Noguchi’s outpatient offices, however, are less crowded because of the outreach services the hospital has in nearby primary health care centres and, also, because they have a triage process where they only take in patients with a certain degree of severity. Given that these conditions are not found at Hospital Valdizán and the follow-up process is fraught with difficulties, the amount of control that can be achieved by the psychiatrist comes under threat. Furthermore, the

task of checking on patients that do not return to the hospital is one that has always been neglected. Even at Noguchi the number of social workers is low, as one practitioner told me: “We have 50,000 clinical records approximately. There must be 15,000 active patients and we only have seven social workers in the whole institute. It's not enough.”

## Psychiatric Assessment

I am going to start my analysis of outpatient consultations focusing on what practitioners do first; assessing what is wrong with the patient. Psychiatrists centre their attention foremost on individual symptoms that are linked to diagnostic labels. In the consultations I observed, the most solicited symptoms were those related to depression (the patient's mood, suicidal thoughts, lack of motivation, etc.). Patients with psychosis and anxiety-related symptoms were much fewer in number. Furthermore, although to a smaller extent, psychiatrists also look for triggers, or risk factors, that exacerbate pathology. In my experience, signs of risk were most commonly searched for in patients' social network (relationships with family members or partner) and in their personality. For instance, patients were described as being hedonistic, impulsive or having a histrionic personality.

I found the style of questioning to be similar to the medical interview: psychiatrists asking questions frequently and patients answering them briefly. As in the case of general doctors, they are embarked on a fact-finding enterprise where they try to gather information regarding symptomatology and risk factors. Questions about specific symptoms—linked to the psychiatric problem at hand—were typical, as if going through a checklist. There was, however, variation in the general style of interviewing. While some would make open-ended follow-up queries to the patient's narration of his or her problems, others would be more directive, often making questions that contained implied presuppositions. This can be seen, for example, in the following list of questions that a psychiatrist asked a patient that had suffered sexual abuse in a five minute lapse of time:

Are you constantly sad? Can you sleep? Do you have nightmares about what happened to you? Do you remember much of what happened? When you

remember, how does your body react? Does your heart beat a lot? Do you feel you cannot breathe? Do you sweat? How do you feel your muscles? How is your diet? Do you feel afraid about your dad being in your house? Do you feel afraid at night? What does your mum say? From 0 to 10, how sad are you? Do you cry frequently? Have you spoken about this to someone?

I felt this psychiatrist had the tendency of jumping to conclusions. Although this was not the norm, there was one day when she could only see the patient for fifteen minutes. It was a woman whose son had been killed by gang members a year ago. She asked her if she was sleeping well and if she saw images of her son “like in a movie”. The woman cried, saying that she would never see her son again and that it was not fair. She dismissed her with a prescription of an antidepressant and an anxiolytic and a promise of psychotherapy in the future. When the patient left, the psychiatrist told me—with much confidence—“she has post-traumatic stress and depression.” I was surprised by the level of certainty she reached after such a limited consultation.

There was another psychiatrist who distinguished himself from this style, telling me he did not “inquire insistently for specific symptoms”, but rather “let the symptoms emerge from the patient's discourse”. He called this naturalism. I could gather, from what I observed and talked with him, that he was quite cautious when analysing patients. He did not rush into a diagnosis.

Writing up the case in a clinical chart is an essential component of psychiatric assessment, one that enables the process of treatment to be set in motion. Its importance was made clear in a number of occasions when the nurses could not find a patient's chart and the practitioner refused to see the patient because of this. Psychiatrists took notes extensively during the clinical interview, interrupting the interaction, while the patient or a family member were talking, or after the interview ended. I inferred two basic functions of the medical chart in the practice of psychiatrists. The first one is recording the treatment process. The consultation is part of an evolving course of rationally planned stages that are interconnected with each other. Thus, clinical records facilitate a diachronic view of the case and allow practitioners to pick up treatment from where it was left off. The second use is as an analytical support. Psychiatrists have to ensure they write down their notes in such a way that it will allow them to make a good interpretation of the case later on. This use of the medical record was exemplified by one psychiatrist who usually stayed in the consultation room

“studying” the charts after his shift was over.

In the same way as general practitioners, psychiatrists arrive at presumptive diagnoses, which are preliminary interpretations of what is wrong with the patient and that need further confirmation. The difference, however, is that psychiatry cannot obtain unequivocal results in this search for confirmation, in the way general medicine does, because there are no biological markers that indicate the presence of a disorder. Thus, psychiatrists have to make use of a number of strategies in order to attain a higher level of reliability in their diagnoses. In addition to their own individual questioning and observation, they refer the patient to a neurologist or other kind of specialist who can discard the presence of underlying medical causes; they ask for the Psychology Department to apply diagnostic tests, and they interview the patient's family in order to get a richer picture of the situation. Another way of pursuing higher reliability would be consulting other psychiatrists in cases where the diagnosis is not clear, but there are no formal instances of case discussion within the outpatient area and, thus, it has to be done informally.

The Diagnostic and Statistical Manual of Mental Disorders III (DSM-III) was elaborated in 1980 by the American Psychiatric Association, partly as an effort to counter the unreliability of psychiatric diagnoses. The great variability in diagnostic practices among specialists was latent and there was hope that a standardised classification of diagnostic labels, which assigned a set of criteria for each one, would ameliorate the problem (Lakoff, 2006, pp. 34-35). The manual has ever since enjoyed a great deal of success globally and is used in places such as Peru in the education of psychiatrists. Peruvian psychiatrists are obliged by law to use the WHO's International Classification of Diseases (ICD-10) when diagnosing patients, but they are also exposed to the DSM during their training. In my experience, they did not show any preference between the two. In fact, most of them downplayed the role of manuals in the clinical setting. Only two psychiatrists seemed to grant them considerable relevance. One of them, a middle-aged clinician and researcher from Noguchi, highlighted that the theoretical basis for most of the research and clinical work done in Peru derives from the “American model”. The other one, a younger biologically-oriented practitioner from Hospital Valdezán, thought that using the manuals in clinical practice is “like reading the menu. You have to read all of it so that you know the pathologies, or else you will misdiagnose or miss the diagnosis.”

The general pattern I found among practitioners was one of caution when referring to the manuals. They warned against the excess of diagnosing a disorder by check-listing a set of criteria. A young psychiatrist from Noguchi considered that clinical reality could not be reduced to the picture presented by the manuals: “Clinical reality is sovereign. It frequently presents itself differently to what the paper says. It is what will tell me what to do, or what not to do, how to diagnose, or what diagnosis to discard.” A standardised list of criteria, for them, poses the threat of obscuring the particularities and complexity of each patient, elements which they consider useful when making a diagnosis. Furthermore, as a Valdizán psychiatrist mentioned, diagnosing is not limited to the patient's symptoms. Psychiatrists should also make note of context when addressing a person's story.

The manuals, I was told, are a mere guide. A theoretical reference that psychiatrists have when analysing a patient. They did recognise, however, their use as a means of communication among practitioners. They provide a shared language in the hospital. They also allow the institution to register diagnostic prevalences in their statistical record.

## Psychiatric Treatment

Psychopharmacology is outpatient treatment's most constant element. It was present in most of the consultations I observed, although there were a small number of occasions when psychiatrists did not use it. At Hospital Valdizán there is no previous screening process for patients, so a “non-psychiatric” case can end up in the hands of practitioners. This is not very common, however. It only happened once in my presence, the case of a middle-aged man who had doubts about leaving his wife and going away with his lover. Other cases were a woman whose depressive symptoms were not judged as deserving medication and another woman who had to interrupt her drug regimen because she was breastfeeding.

Despite the widespread acceptance and use of pharmacology in these spaces, the topic does not remain completely unproblematised. There are certain anxieties that surround it. For instance, many psychiatrists expressed negative feelings towards the mercantilist intentions of “los laboratorios”—this is how the pharmaceutical industry was referred to—and the influence they try to exert on them. Moreover, a psychiatrist from



Noguchi's emergency unit expressed his concern over psychiatric practice being reduced to pharmacology:

It's like a dermatological consultation: this symptom goes with this drug. Five minutes. The human being is more than a sick organ. More so in psychiatry because we cannot talk about a sick brain. The human being does not operate with molecules; it does with values, motivations and meaning. This is not attained working only with criteria and giving pills to people. But this style is very extended, the North American psychiatry style.

Psychopharmaceuticals, then, are not overpraised, but they are inevitably a central matter of concern due to their high usage. Luis (chapter three) was the practitioner who showed the most interest in them. A young doctor who had done his residency in a biologically-oriented psychiatric department, he usually talked, to me or colleagues, about the latest tendencies in psychopharmacology, be it the newest pills on the market or specific innovations that were being made in the field. I did not find his level of enthusiasm in other practitioners, however.

Psychiatrists use psychopharmaceuticals to ameliorate specific symptoms. They hand out antidepressants because they want to alleviate depressed moods or intense anguish. This keeps patients stable, preventing them from falling into acute episodes of crisis. They are perceived, nevertheless, as insufficient for recovery. Psychological interventions are needed to attain a higher level of improvement. At the same time, given that it would not be possible to grasp recovery without the stability of symptoms that pills are able to achieve, they are presumed to be necessary.

Two psychiatrists cautioned me against the dangers of over-medicalisation. One of them was a middle-aged practitioner from Hospital Valdizán and the other a younger doctor from Noguchi. For starters, they contend, psychiatrists can medicate people with milder problems that can be solved without the use of pills. Furthermore, pharmacological practice needs to be addressed in a rational, evidence-based manner. "Give them the necessary minimum," they told me. The Noguchi psychiatrist had seen a patient who was receiving four different antipsychotic drugs at the same time in the day hospital of another institution. "It did not follow any technical criteria. There is no reason for having an overly sedated patient," he observed. Following a similar logic, the other doctor was wary of the unnecessary extension of pharmaceutical regimens over time. In his Valdizán consultations, he sometimes preferred to delay the prescription of a drug if

he was not sure about the decision and at times expressed his concern about medicating the patient for too long.

Practitioners expressed most restraint in the use of benzodiazepines because they are regarded as addictive. They were sometimes avoided or prescribed for limited amounts of time, and patients were told that they were not necessary or good for them.

In terms of medication management, I found practices to be quite homogeneous in general. I am going to refer specifically to the handling of antidepressants, one of the most used kind of drug in the hospitals, although many of what will be said can also be applied to other psychopharmaceuticals. Psychiatrists typically used two generics, sertraline or fluoxetine, in their first encounter with a patient showing signs of depression. The second meeting was usually scheduled two weeks later because this is thought to be the time these pills take to have their first therapeutic effects on the patient. At this point, psychiatrists start following up on how medications act on patients and making adjustments over time. In one of our conversations, Luis told me he enjoyed this part of the job: "It's nice. It's like alchemy: you see what to prescribe according to how the patient is doing." The desired outcome is to arrive at an ideal dosage that keeps symptoms at bay.

If the medication does not make the patient feel better, or if he or she is getting worse, then the practitioner will raise the dose. If this does not work, another antidepressant can be used. If symptoms continue being treatment-resistant, the psychiatrist can use combinations of more than one drug or "last resort" treatments. For example, the treatment of schizophrenia starts with one antipsychotic, then it can be upgraded to a combination of antipsychotics and, finally, if the patient continues to be unresponsive, clozapine is used. Clozapine is effective for treatment-resistant schizophrenia but can have dangerous side effects. On the other hand, when patients get better, psychiatrists stick to the dose and leave them on autopilot until further notice. Reducing the medication when the patient shows improvement is considered a mistake that can push the patient towards relapse. Generally, the amount of time a patient has to take his antidepressants is, if all goes well, one year. During this time, the frequency of appointments grows sparser as the patient gets better. Finally, the practitioner discontinues the medication.

Prescription practices between doctors were similar because they are determined by the price of medicines and the patient's personal economy. Most patients are offered

the cheapest generic antidepressants, fluoxetine or sertraline. These, and other drugs, are offered by the hospital at discounted rates. The hospital does not always have them in stock, however, so sometimes patients have to buy them at higher prices in regular pharmacies.

The difference in prices with brand name drugs is big. In one of our conversations, Luis talked about the latest anti-depressant on the market, Pristiq: “Each pill costs 16 soles (£3.6). Even I cannot buy that, it would compromise my economy.” Expensive drugs are mostly used in the private practices of psychiatrists that only use generics in the public hospital. Needless to say, only patients that have enough purchasing power have access to this service. This double standard of treatment poses a number of limitations that, allegedly, generate a wide quality gap in the two sectors. First, psychiatrists complain about the limited choice they have when trying to find the ideal pill for their patients, as one Noguchi practitioner expressed:

There are times when we have to change it but we can't because each pill costs 15 to 20 soles (£3.4 – £4.5). Most patients here have a low economic status. That's a limitation, not being able to choose the drug freely.

Secondly, whereas in the public hospital any type of depression or anxiety problem is treated with the same drugs, in private practice they have the possibility of using more targeted treatment. For example, paroxetine is better than sertraline for anxiety disorders, but it is economically out of reach for most patients.

Another disadvantage of using generics, every psychiatrist agreed, is that they have more side-effects than the originals and than newer drugs. Psychiatrists think that, although they contain the same active ingredient, generics are of lower quality due to how they have been produced by local laboratories. “When patients take them, they dilute faster and it leaves a bitter aftertaste or produces a burning sensation,” one Larco Herrera psychiatrist told me. “If you give them Prozac, 20 mg of fluoxetine are enough. With the generics, you have to give them 40 to get a therapeutic response,” she added. She thought that generics have a smaller amount of active ingredient and more excipients. Similarly, a Valdizán psychiatrist told me that the government does not make bioavailability studies for pharmaceuticals, which would inform doctors of the dosage needed and the therapeutic time rate of each drug. Thus, in their view, they start treatment without knowing how good a generic is and find out through experience.

Psychiatrists had different ways of transmitting this information, or failing to do so, to patients. A first scenario is one where they just prescribe the generic and do not provide any more information to the patient. This form of proceeding was encouraged by a wariness they felt towards the act of promoting brand-name drugs. This is seen as unethical because, given that brand name drugs and generics are the same, it does not make sense to promote the expensive option. Another way of going about it is to recommend the best pharmaceutical options to patients only if they ask. Finally, psychiatrists can openly lay the cards on the table by telling patients that they have a choice: the cheap pills that can be bought in the public hospital or better and more expensive versions that have to be purchased in private pharmacies. Although this seems reasonable, telling patients that generics are less effective could make them susceptible to an unfavourable therapeutic outcome, a response akin to the nocebo effect.

During my engagement with schizophrenia patients from Hospital Valdizán and their families in 2007, I observed how they explored ways of finding brand name drugs at reduced prices by asking people they know in the healthcare system or searching for pharmacies or laboratories that offer discounted prices. On one occasion of my most recent fieldwork, when I was sitting in a consultation room, the patient asked where he could get a specific brand name antidepressant at a discounted price. "It's from Pfizer, right?" the psychiatrist said while searching for a name in his mobile phone. "The pharmaceutical rep told me they give them out to doctors," the patient said inquisitively. "They do with the ones who beg for it," the psychiatrist replied. He then called a man and asked for the number of Pfizer's pharmaceutical sales representative and gave it to the patient so that he could continue his search.

A significant aspect of psychopharmaceutical consumption is experiencing side effects. Headaches, nausea, sexual dysfunction, sleepiness, weight gain, and increased risk of heart disease and diabetes are just some of the complications that may affect patients when they take these pills. In 2007, I saw a diverse set of negative emotions triggered by the onset of side effects. Sometimes patients expressed utter contempt towards drugs and a desire to stop taking them. Family members also became concerned, like the case of a son whose mother became sick and threw up when taking an antidepressant; two sisters who lamented the facial tics that antipsychotics induced on their brother; or a father who was perturbed by the intense

headache his son was enduring after taking an antipsychotic. While psychiatrists perceive side effects as a necessary evil that can be handled, patients and their families see them as a destabilising experience that can make them question the value of psychopharmaceuticals.

This issue, along with the economic factor and the fact that these drugs have to be taken for prolonged periods of time, increases the probability that the patient will, at some point, stop treatment. A 1982 report from the short-lived unit of patient follow-up at Hospital Valdizán (Rojo and Montoya, 1983), for example, claimed that only 17% of patients who had been hospitalised the previous year had continued outpatient treatment. Among the patients found at home, 53% had discontinued treatment, 29% had changed to other mental health services, 8% had interrupted their treatment temporarily, 7% had been abandoned by their families, and 4% had to be hospitalised again. Discontinuing treatment was associated with factors such as family problems, living far from the hospital, economic difficulties, and the quality of care provided by the hospital.

Beyond all of these constraints, people express concerns about the effectiveness of psychiatric drugs. In my 2007 interviews with family members of patients with schizophrenia, two parents told me that psychopharmaceuticals were useful for calming symptoms but not for curing the illness. Furthermore, the daughter of a patient did not believe in the pills and argued that her father would be cured with prayers and good family care. In addition to this, families stated that stopping psychotropics caused patients to suffer severe relapses, as they had purportedly learnt from their experience. This perception may have been reinforced by the fact that one of the most emphasised instructions by hospital personnel is that patients cannot stop taking their medications and that they should talk with their doctor if they want to change the treatment plan. Another common message about psychopharmaceuticals was related to the temporality of treatment. Psychiatrists used to tell the patient, or family members, that they would have to wait a couple of weeks for a certain pill to have an effect, or that psychiatric treatment had a medium to long-term temporal framework.

Psychiatrists also informed patients about the type of practices they should avoid, such as drinking alcohol or coffee. Information about side effects, however, was remarkably scarce. It came most commonly in a reactive form, when patients had already taken the drugs and were complaining about these effects in the consultation

room. I rarely saw a practitioner warn about this topic beforehand. A valid inquiry here would be to find out how patients would react if they were initially presented with the list of possible side effects of psychopharmaceuticals.

## Psychotherapies

After medication comes psychotherapy. The patient's debilitating symptoms have to be mitigated first in order for psychiatrists to think about making this step. They do not apply it at Hospital Valdizán's outpatient area, however, due to the time constraints I have discussed, but save it for their private practices. Every practitioner that I engaged with thought psychotherapy is necessary for achieving improvement and applied it themselves or referred patients to a therapist. When asked how many of their colleagues had studied a specific type of psychotherapy, their answers fluctuated from 50% to 70%. Interest in psychotherapies, nevertheless, has grown among the younger generations.

The psychotherapeutic practices that I found among my informants were varied. Some of them just apply a low-complexity form called supportive psychotherapy, which consists in actions such as listening, comforting, raising the patient's self-esteem, and helping to sort out and deal with their problems. Others apply tools from specific psychotherapeutic perspectives but in a reduced format, choosing to refer patients with complex problems to psychotherapists.

Two psychiatrists from my research cohort, the most “medicalised”, excluded any type of guidance that was not related to the psychiatric disorder at hand and psychopharmaceuticals. One of them viewed his role as consisting exclusively of determining a diagnosis and treatment plan, excluding any other type of counselling from his repertoire. He made this explicit in one consultation, when a mother pleaded him to tell her son that he does not have to be sick to go to the hospital. He addressed the young boy saying: “You don't have to be sick to come for counselling, but that is given by the psychologist. You can tell the nurse if you want to see the psychologist.” In the context of the busy outpatient area, staying within the limits of the medical role can also be seen as a time-saving strategy.

There were two other practitioners at Hospital Valdizán who did offer a wealth of guidance, beyond that related to disorders and treatment, in the clinical encounter. One

of them had a strong interest in psychotherapies and offered extensive counselling to patients, mostly in the form of personal coping strategies and interpersonal relationship advice. The other, who was taught psychological counselling during his residency at a general hospital, also focused on interpersonal relations. He did not, however, provide much guidance on how to deal with personal emotions or thoughts and, instead, centred his attention on women's economic situation. He advised them, with much insistence, to get a job in order to maintain their children, if they had any, and break the ties of dependence with their, sometimes violent, husbands or families. For example, once he was discussing the current state of a young woman who had moved from her parents' house into a squatter settlement, where living conditions were not easy to bear. "What are you going to do?" he asked. "If you go back to your house, there is no independence. You have to make a decision. In the squatter settlement you would have to work, but you don't want to take responsibility." "Yes, step by step," she replied.

Universities include courses or seminars of psychotherapies in their residency programmes and, additionally, residents rotate for a month in the two psychotherapy departments of Hospital Valdizán, the Department of Cognitive Behavioural Therapy (DCBT) and the Department of Family Therapy. In this way, psychotherapy appears as an optional path to take. Universities and hospitals introduce residents to some psychotherapies and they have to decide if they pursue the study of one, or more, of these perspectives after finishing their programme. But psychotherapy degrees today are not taught within the hospital, patients have to study them at private institutes for two or three years. Thus, although it exists, the psychotherapeutic component of psychiatric residency is marginal compared to other aspects of professional training.

Hospital Valdizán offers three psychotherapeutic services, the ones just mentioned and an area of psychoanalytic therapy (Instituto Noguchi does not have psychotherapy services). The most commonly practised psychotherapy, in general, was cognitive behavioural therapy (CBT), followed by systemic therapy and, to a smaller extent, psychoanalysis. The cognitive behavioural and systemic areas are managed by two psychiatrists who work with teams of psychologists. In the psychoanalysis area there is a small number of psychiatrists practising therapy. Given the fact that these services are unique in their kind in the public health system, they have a lot of demand—specially the CBT and systemic services—and not enough personnel to meet it. Thus, there is a long waiting list that can obstruct the ideal course of treatment within these

modalities.

In the following lines I will review how these three psychotherapeutic perspectives were defined and valued by psychiatrists from Hospital Valdizán. Since I did not observe psychotherapeutic sessions of any kind, the information contained here is exclusively based on practitioner self-report. Thus, this section is about what psychiatrists think about these psychotherapeutic paradigms and how they inform their professional identity, as opposed to how they practice them. The latter option allows the ethnographer to develop a critical account that compares what practitioners say with what they do and to encounter further lines of interpretation that extend beyond explicit discourse. Van Dongen's (2004) analysis of therapist-patient interactions in a Dutch psychiatric hospital is a good example of this. She found that therapists viewed psychotic expressions as an obstacle and excluded their exploration in the therapeutic process (Van Dongen, 2004, p. 219). This attitude turned therapeutic encounters into antagonistic struggles characterised by "ambivalence, paradox, irreconcilable contradictions and double messages" (Van Dongen, 2004, p. 230). The author, instead, argues that psychotic discourse can be regarded as a way of coping with the trials and tribulations of the illness through the use of cultural rhetoric. In this sense, it "displays evidence of intention, resistance, and comment on the values, norms and rules of Dutch culture, and expresses a deeply felt desire for freedom, happiness, and peace" (Van Dongen, 2004, p. 221). An approach that would yield improved therapeutic results would entail listening to psychotic discourse and establishing a collaborative exploration and working through of existential issues and cultural contradictions (Van Dongen, 2004, pp. 232-233).

The DCBT was opened in the mid-1970s by Dr Navarro, who was the hospital's director at the time, and a psychologist. They studied cognitive-behavioural therapy in Berlin for three years before returning and establishing an academy and the Valdizán service. Over the years, they have educated many psychologists and psychiatrists and have turned CBT into a highly valued asset in the repertoire of the Peruvian psychiatrist. CBT is most practitioners' psychotherapy of choice. Even if they did not have time to apply it in the public hospital, they made frequent patient referrals to this service.

CBT was talked about by psychiatrists as a pragmatic form of psychotherapy that is meant to change problematical modes of conduct or thought through a set of practical



strategies. As it was described by them, it stands out as a directive and top-down therapeutic practice: the patient is told to accept a way of looking at his experience and how he has to change. Psychiatrists stated the following aims of CBT: modifying conduct and wrong ideas, changing ways of thinking, taking out ideas and changing them for new ones, and applying psychological techniques for anxiety control. These goals are highly compatible with psychoeducation, the task of “educating” the patient in a way of perceiving and responding to his or her illness. This effort can be seen in the following excerpt of a young Valdizán psychiatrist describing her interaction with a patient with schizophrenia:

I tell the patient how he has to see his delusions. That it is a delusion, that it is happening because of his illness. The patient becomes more aware and starts to identify his delusions and hallucinations. He learns how to manage it. For example, a patient told me that he feels someone is stealing a part of his body. So I told him: “Do other people have this type of thought? No. Then, what is that thought?” He becomes aware that it is a delusion. And what is a delusion? A part of my disease. Additionally, they learn that they will feel much better if they take their medication.

I got a host of positive comments about CBT in my time spent with practitioners. For starters, it is seen as the most evidence-based psychotherapy, the only one that has been tested in studies, and as being “measurable”. It is straightforward to see if it works in the short-term. Furthermore, it is seen as the best suited one for the public sector, where time constraints and resource scarcity call for a shorter, cost-effective, psychotherapy.

The second most popular psychotherapy was systemic therapy, alternatively known as family therapy. I did not get as much insight into this therapy since only two of the psychiatrists that I interviewed had studied it. Referrals to Valdizán's systemic area happened, occasionally, when complex family problems were found. Systemic-oriented family therapy also has a pragmatic, problem-solving, orientation. According to Hospital Valdizán's website, it is important for helping families manage transitional phases or stressful life events. This management of troubles is achieved through the development of coping strategies and problem-solving abilities that seek to enhance mutual understanding and emotional support among family members. While CBT focuses on the individual, teaching him strategies to overcome his personal problems, systemic

therapy focuses in the immediate social context of the family, trying to strengthen the relational resources found within this sphere.

Finally, the Service of Psychodynamic Psychotherapy is the last one to have been created. They could not make it a department within the hospital's organisational structure, with the same status as the other two psychotherapies, because there was opposition from other psychiatrists who see psychoanalysis as outdated and unscientific. They made it past this obstacle, however, by seeking the help of the Department of Family Therapy, which ended up accommodating them within its administrative structure.

Despite being the least popular of the three psychotherapies, it was the one with the highest number of practitioners applying it in the hospital (as I mentioned above, the other two psychotherapy areas only have one psychiatrist each). This small group of psychiatrists had formed a shared identity as psychodynamic therapists, which led them to hold periodic meetings where they discussed their craft and specific cases they were treating, as well as develop friendships. I had the chance to talk with one of these psychotherapists, Dr Leguía, over the course of several meetings we held in his office. The idiosyncratic nature of his office was evident when compared to other personal spaces within the hospital. This one actually looked like a personal space: it had pictures, decoration, a bookshelf, and so on. The first one of our chats took place with classical music, while on another occasion he was listening to a radio station from Spain, which struck me as odd. At first impression, he seemed to conform well to the psychoanalyst stereotype. He was serious and composed, talked slowly as if cautiously analysing things, and maintained an air of cultivation and worldliness.

Dr Leguía was quick to assert his identity as a psychoanalyst and distance himself from biomedical psychiatry. In our first encounter, he described how he became interested in the field:

I never wanted to be a doctor. But once I was watching an old television show, called Dr Kildare, and there was a woman who arrived at the ER in pain. Dr Kildare, who at the time was an intern, tried to solve the case but the woman did not have anything. Nothing detectable. His tutor, Dr Gillespie, a very measured person, very wise, told him: "Go to this doctor's office on another floor." And then you see that this doctor starts treating the woman in a totally different way. He starts to explore her psychology, other stuff that is not physical. And that is what interested me. That mystery, that additional thing that we have. At the end of the

episode, I learnt that he was a psychiatrist and I told myself: “I want to be a psychiatrist so that I can study that”. But then I was surprised to know I had to study medicine to be a psychiatrist. I had never thought about being a doctor, but due to my great interest, I went through the medicine years and finally did my residency. It was not until those years that I learnt that, in order to be the type of psychiatrist I wanted to be, I had to study psychotherapy separately. And so I studied psychotherapy courses and, most importantly, I was taught psychoanalytic psychotherapy by my mentor for about seven years (on the wall behind him was a framed picture of him and his mentor, a man with white hair and a beard). I had finally arrived at that image I first had.

Psychoanalysts have a different way of looking at individuals and their mental health. Dr Leguía focuses on resolving the problems of “people that have conflicts and traumas”. As it is well known, these problems are often thought to be unknown to the individual and therapy is used to elicit and resolve them. Leguía juxtaposed his psychoanalytical approach to the hegemonic biomedical focus of contemporary psychiatry. In his view, while medicalised psychiatry focuses on disease labels and empirical inquiry, psychoanalysis centres its attention on interpretation and people’s subjectivity:

The psychiatry I found in real life is very different from the one practiced by that doctor on the Dr Kildare television show. Psychiatry right now is very medicalised and I don't like that. They don't work with the person, just with the disease. I was interested in studying and understanding the human soul. But societies have become more objectivistic and pragmatic due to economic and industrial factors. Evaluations only take results and numbers into account. This worldview also permeates psychiatry and the training of psychiatrists. Subjectivity barely counts anymore. They are only trained to detect diseases, using questionnaires, and treat them like any other physical ailment. We are a result of our culture.

Leguía here clearly disparages psychiatry in its current state, seeing it as superficial, just as the culture we live in. In contrast, psychoanalysis represents depth. His training lasted six years, patient sessions are longer, and you have to dig in into the unconscious of people to really understand them. Relationships with patients also seem to be more profound. When I first asked him if he held consultations in the hospital he immediately replied: “Yes, but they are private”. While all the other psychiatrists did not mind my presence in consultations, Leguía depicted his sessions as too intimate for a third party to intrude. This distinction seems to be generated by psychoanalysis’ inclusion of the subjective and moral character of its endeavour, as opposed to the

objectivistic and morally neutral nature of biomedical psychiatry. While intersubjective relationships might be of secondary importance for the latter, they hold a central role in psychoanalytic therapies.

Another difference is the duration of consultations. Psychoanalytic sessions are longer due to the greater amount of talking and exploration that takes place. However, Leguía stated that public health policy has a “cost-effectiveness” mentality (“they want you to see as many patients as you can in order to justify a budget or something”) that prioritises quantity (of patients) over quality (of care). So, in order to increase his “productivity”, instead of holding consultations for forty-five minutes to an hour, he makes them thirty minutes long.

### The Clinical Relationship

In theory, outpatient consultations allow psychiatrists to develop a closer, long-term, relationship with patients. While in the emergency and hospitalisation areas practitioners see patients for a limited amount of time, in outpatient consultations they are supposed to maintain contact for years. This can lead them to feel more personally responsible for the patients’ wellbeing and have a high degree of acquaintance with them. This was not the case with everyone at Hospital Valdizán, however. Some developed this kind of relationship and others did not.

The overcrowded public hospital context does not favour the development of intimate long-term relationships among psychiatrists and patients. Appointments are given every two or three months, but if a patient happens to miss one and goes to the hospital on another occasion, he or she will be seen by a different practitioner who will reschedule the appointment. In these cases, the time-lapse in which patient and doctor do not see each other is doubled, and if this happens repeatedly, then the patient will not be seeing him very much at all. This glitch in the service tends to produce impersonal clinical relationships. Two psychiatrists I interviewed, for instance, did not remember patients they had seen months ago. Furthermore, the medical chart of a patient from my 2007 fieldwork cohort showed that, in a lapse of four years, he had been seen by six different psychiatrists.

A Valdizán psychiatrist, who I will call Dr A, explicitly expressed an impersonal stance on patient-doctor relationships. One afternoon, while I was with him in the

consultation room, I asked if he was seeing other doctors' patients, to which he replied: "I don't think doctors own patients." He represents the objectivist view that doctors are interchangeable. It does not matter who specifically treats a patient because they are supposed to have the same scientific criteria for observation and treatment. As a counterpoint to this perspective, there was another practitioner, Dr B, who expressed a different outlook. A seventy-one-year-old man entered the consultation office and Dr B saw in his chart that he had another attending psychiatrist. "I was moved here," the patient said. Before carrying out the consultation, he went out of the room and arranged the patient's next appointment with his original doctor. "She can see you next time. She knows you better, let's not cut that relationship," he observed as he sat back on his chair.

Dr B's demeanour in the consultation showed a higher degree of familiarity with patients. He always called them by their name, sometimes adding a diminutive that in Spanish expresses fondness ("Rosita", for example). He also remembered other aspects of their lives, such as when he asked a patient how her sister was, or when he asked another patient if she had fallen in love again because that is what she always used to do. Furthermore, he usually received calls from patients on his mobile phone, a sign of the receptive attitude he maintained towards them.

For his part, Dr A thought of consultations just as the task of diagnosing and treating mental disease, leaving out the possibility of developing meaningful relationships with patients. He usually had an agitated posture, with his legs shaking and sitting at the edge of his seat, which could come across as a sign of impatience. He maintained a neutral disposition towards patients and their families when they were in distress and at times was curt in his exchange with them.

Among the other psychiatrists I observed at Hospital Valdizán's outpatient area, Dr C was the one who had the most sympathetic attitude towards patients. A comforting tone of voice and reassuring words were almost permanent elements of her repertoire. Another psychiatrist, Dr D, sometimes had a caring and attentive attitude, but on occasions turned impatient and condescending, with a negative stance towards the patient. It became clear that he did not like some of the traits he found in patients. For example, after one consultation, he told me that the patient, a woman, was histrionic, difficult to communicate with, and did not like responsibility. On another occasion, he said: "This patient contradicts herself, is antagonistic, plays the victim, and is histrionic.

My mom is also like this and I have endured it all of my life. I need to be prepared for this type of patient.” Dr A also showed some annoyance when he met a patient with schizophrenia and his mother at Hospital Valdizán one afternoon. He thought, and explicitly told them, that the patient was lying about not being able to sleep, implying that he was just manipulating his mother. He ignored the patient at times and threatened him with hospitalisation if he did not sleep. When they left the room, Dr A told me that people with schizophrenia are annoying.

Patients are able to choose their psychiatrist at the outpatient area. In both of my fieldworks (2007 and 2012-2013), I saw patients and family members complaining about specific doctors and changing them. One patient, for instance, told me she changed her practitioner because he was too arrogant. Psychiatrists can also be picked out for their positive attributes, like when a patient told Dr B that she asked for him at the outpatient area because she had liked him when she was hospitalised (Dr B also worked in a hospitalisation ward).

In the typical psychiatrist-patient relationship of the hospital, the locus of agency is tilted towards the practitioner. Dr Leguía, to start off with a contrasting example, grants the patient more control over therapy, as he stated in the following:

My psychotherapy, because of its psychodynamic orientation, is not directive. Patients have the initiative. I'm not going to tell him what to do and what not to do, what to think and what not to think. The patient will learn and determine this by himself throughout therapy.

Similarly, Dr D told me he did not like to create dependency in his patients. Instead of telling patients exactly what to do in specific situations, he prefers to make them think and arrive at their own conclusions. This is only true, however, in his private practice, set in a middle class district of Lima. In the public hospital he adopted a more paternalistic attitude towards some of his patients. For example, he once told me that a patient had a low intellectual level, was hard to understand and he had to tell her what to do very clearly. He enjoyed himself more with the middle-class, well-educated, patients from his private practice.

Complaints about the difficulties created by social class differences between psychiatrists and patients also emerged among other practitioners. Dr Leguía, for instance, told me that Peruvians are generally “primitive”, “ignorant”, and hard to

communicate with. Instead of acknowledging the vast social gap existing in the clinical encounter in a non-judgemental way, these psychiatrists perceive patients negatively for not fulfilling the expectations of their own sociocultural perspective.

## Discussion

The psychiatric practice I witnessed in outpatient consultations at Hospital Valdizán is similar to what anthropologists in the past have described as the biomedical model of American psychiatry—also referred to as the Neo-Kraepelinian paradigm—, which started to take form in the 1980s (Good, 1992; Kleinman, 1988; Littlewood, 2002; Luhmann, 2001). In the lapse of short consultations, lasting on average from 13 to 20 minutes, practitioners looked for the fixed patterns of symptoms and environmental stressors that make up prototypical psychiatric disorders, and which would allow them to arrive at a diagnosis and assess the service user's evolution in follow-up consultations. They decide psychopharmaceutical prescription and modulation based on this appraisal of symptoms. Follow-up consultations are centred around “med-checking” (Oldani, 2014), with some amount of counselling depending on the practitioner, and excluding psychotherapies due to lack of interest and time restrictions.

As I have discussed, users and families commonly show discomfort towards the so-called side effects of psychopharmaceuticals and fear their withdrawal effects.<sup>21</sup> Users' concerns and resistance towards psychiatric drugs have been documented in the anthropological literature (Leibing and Collin, 2013; Pope, 2015; Behague, 2016; Read, 2012), and the centrality of side-effects to patient experience has been contrasted to how they are trivialised by doctors (Ospina, 2011, p. 265-266). Another perceived limitation of pills is that they control acute symptomatology, but do not achieve complete cure (Jenkins, 2005, p. 398-400; Kaljee and Beardsley, 1992, p. 274). People sometimes question psychotropics because they weaken their capacity to work, which is frequently a key aspect of subjective recovery (Read, 2012, p. 445; Leibing and Collin, 2013, p. 410). Critical researchers have also raised their concerns over the efficacy and harmful effects of psychopharmaceuticals in high-income countries (Bracken et al., 2012; Moncrieff, 2013; Milles and White, 2017, pp. 191-192).

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<sup>21</sup> For a description of the withdrawal effects caused by antipsychotics and a review of the research on this matter, see Moncrieff (2013, p. 93-96).

In the 1980s, Hospital Valdizán's short-lived unit of patient follow-up found that most previously hospitalised patients had discontinued their pharmacological treatment (Rojo and Montoya, 1983), a finding that has been ratified by more current studies in both poor and wealthy contexts (Jenkins and Kozelka, 2017, p. 155). The anthropological literature also documents the experience of patients who do adhere to pills at a specific moment of their illness trajectory or in the long run. In her critical autoethnography of psychiatric hospitalisation, Ospina (2011, p. 262) narrates how she developed an attachment to anxiolytics because they effectively anaesthetised the anguish she felt. Longhofer and Floersch (2010, p. 168) illustrate how patients can evolve from "wanting specific symptoms to disappear to the treatment of an ongoing illness." They turn into medicalised selves (Pope, 2015) with a steady illness identity and a continuous course of treatment. In the first stage, medicines are used to eliminate symptoms, while they are later used to prevent them from reappearing. Furthermore, Behague (2016) and Kaljee and Beardsley's (1992) accounts show that a determining variable for chronic medication use is socioeconomic status. People with less treatment options available and fewer opportunities for social improvement seem to be more prone to go down the biochemical path permanently.

In contexts where the social gap between psychiatrists and patients is of a considerable size, the task of persuasion is particularly challenging. First of all, patients have to be persuaded that they have a disease, that they need help, and that medicines will be beneficial for them. Furthermore, they have to persuade family members, who may not be willing to accept the disease or may want to abandon the patient, that they have a sick person in their household that needs their help. The importance of persuasion was once expressed to me by Dr C after a consultation: "At first the patient was suspicious, she did not accept any interpretation but her own. But then she realised that she needed help. This is important because it means that the patient will follow your advice without doubting you."

Persuasion is the first part of what in the mental health field is known as psychoeducation, which also comprises teaching patients and their families specific knowledge about the disease (how to identify relapse symptoms, for example), about pharmacological treatment and other general guidance for patient care or self-care within the household. Psychoeducation is not an exclusive domain of psychiatrists. Special psychoeducation workshops at Hospital Valdizán and Instituto Noguchi are



usually run by nurses and social workers. In the case of psychiatrists, time constraints within the hospital do not allow them to engage too much in the practice. Dr D, for instance, mentioned that he could easily spend half an hour doing psychoeducation in his private practice, while in the hospital this is seen as an excessive amount of time to spend with a patient.

Rhodes (1984) and Ecks (2014) illustrate how psychiatrists in different settings use metaphors based on experience-near idioms and cultural scripts in order to improve communication with users and successfully persuade them into adhering to psychopharmaceuticals. Similarly, other authors argue that cultural brokerage and the use of cultural concepts of distress improve clinical communication and service usage (Poltorak, 2016; Kaiser et al., 2015, p. 171). These strategies can also be applied in favour of public mental health campaigns and stigma reduction activities (Kaiser et al., 2015, p. 180; Poltorak, 2016, pp. 753-755).

At Hospital Valdizán, the way in which the outpatient service is structured, the sociocultural distance between psychiatrists and service users, and the views and attitudes of some practitioners generate an impoverished doctor-patient relationship that ultimately diminishes psychiatry's chances of success. Although my main research sample included only a small number of practitioners, I can confidently argue—based on additional interviews and the time spent in the hospital—that this scenario spreads beyond them.

## The Hospitalisation Wards

It was a winter morning when I decided to go into the hospitalisation wards for the first time. These, along with other areas, were in the inner part of the hospital, separated from the outer side by a wall. The guard from the entrance security point did not ask me anything, as I was expecting, when I passed by. As I walked towards one of the main wards, I realised the extent to which my access to this area had been enhanced by the lab coat I was required to wear.

The wards were plain and long one-story buildings. Upon my arrival I encountered a reception desk where a handful of nurses and nursing technicians were carrying out their daily chores. I asked one of the nurses for the psychiatrists' work schedule so that I could know when to find them. Patients were wandering around the hallway and a couple of them approached me. One addressed me as "doctor" and asked if I could interview her, while the other asked me if a particular psychiatrist was within the premises at the time.

The nurse told me that a psychiatrist was doing rounds in one of the rooms down the hallway, so I decided to go and take a look. On my way there, I went past another nurse who was handing out pills to a small line of patients in the hallway. There were two nursing technicians hanging out at the doorway of the room I arrived at. I greeted them and saw a psychiatrist with three or four residents in front of me. They were about to start their rounds. He was wearing normal civilian clothes (I only saw one doctor who wore scrubs in the wards) and did not take notice of me. The room was similar to the hospitalisation rooms of other public hospitals, spacious and with multiple beds at each side. Each bed had, printed at its head, the date of admission, attending doctor, and diagnosis of the patient. I saw one that showed its user had been admitted three days ago and was assigned the diagnostic code of F.33.2, which stands for major depressive disorder in the ICD-10.

One of the technicians encouraged me to join the crowd, but I was not planning to do

that at that moment so I walked away.

## The Wards

At Hospital Valdizán there are two main same-sex hospitalisation wards, in addition to an addictions ward that I did not visit. The most commonly found diagnosis during my visits was schizophrenia, followed by borderline personality and, to a lesser degree, bipolar disorder, depression, and different anxiety disorders.

The wards used to have ninety beds until 1990. Since then, the Ministry of Health has reduced the maximum allowed units per ward to sixty. This tendency to cut back hospitalisation capacity ran parallel to processes of population growth and rise in the use of mental health services, generating a demand for beds that cannot be easily satisfied by the hospital.

In terms of workforce, the wards had four psychiatrists. Some of them worked several days a week and others were there just one or two days per week. The chief of one of the wards told me they would like to have six full-time psychiatrists. They also fell short of nursing technicians, who are the ones that spend more time with the patients.

Having been granted permission to enter the area by hospital authorities, I asked a psychiatrist from each ward if I could follow them in their daily work routine. While one of them accepted without hesitation, the other one's response was ambiguous. He had just returned from a vacation and preferred if I could shadow another doctor first and return later. I took him at his word and did just that. He never really opened up with me, however, maintaining a reserved attitude throughout my ward days.

So I ended up seeing more of these two psychiatrists and the three junior residents who were working in the wards at the time. Nevertheless, there was a stark difference between the two wards in terms of the availability of psychiatrists and the relations they had between each other. In the men's ward, psychiatrists performed their job separately, without interacting with each other in any way. The opposite was true in the women's ward, as I will describe in the following section.

The women's ward had a leader, Dr Loza, an old-timer who had been working there since 1983. He was a light-hearted man that lightened the mood of the ward by being sarcastic and joking with everyone. He sometimes pranked me, for instance. There was

one time when I asked for consent to a woman being interviewed and she accepted but he said “I’m not comfortable”. Or another moment when he was working on the meeting room computer, while I was sitting on the couch, and he suddenly played a song on the computer and left the room without saying goodbye, leaving me confused. I must point out that these episodes were unproblematically interpreted as jokes, since they did not happen in the context of expressed negativity or a bad relationship.

Loza had a close relationship with two of the other psychiatrists of the ward. He had mentored one of them earlier in his career and was friends with the other. In contrast to the men’s ward, they worked collaboratively. They discussed patients and therapies in ward rounds—which they sometimes did jointly—and group meetings, and were open to giving and receiving advice. In addition to this, they held weekly academic meetings where they discussed difficult clinical cases and journal articles. Dr Loza told me these gatherings allowed them to “unify criteria”.

The residents described one clinical case discussion where an eating disorder specialist was invited. They appreciated the openness of the ward psychiatrists who were willing to take advice from external colleagues:

He even modified Dr Loza’s treatment. I like that Dr Loza has the nobility to tell us “I don’t know how to treat that, we were treating it wrongly”. Not wrongly really, but not with the right dose. So the other doctor said “you have to change this and that, you have to increase this dose” and we learnt. The dose had to be increased, we had to weigh her, she couldn’t see her weight... there was a lot we were doing wrong and the doctor corrected us. But it was because he knew, so you don’t take it in a bad way.

Another expression of organised work at the women’s ward was the weekly therapeutic team meetings, where issues and agreements about ward management and patients were discussed. These took place in the meeting room, a small area with a large table that occupies most of the space, a couch, a whiteboard, some shelving, and a small computer desk in the corner. At the entrance, you could find a bulletin board with the names of each psychiatrist and, under these, Post-its with the names of their patients. From my point of view on the couch, I could see the large books they had on the shelves: Comprehensive Textbook of Psychiatry, PK Vademecum, Dictionary of Pharmaceutical Specialties, National Survey of Drug Use and Prevention. I shared the couch with residents, an occupational therapist, and a social worker. The table spots

were taken by the two psychiatrists who were on their shift, one resident, and the chief nurse.

The composition of the meeting expressed the hierarchy of professions, with psychiatrists and nurses at the top of the ladder. The chief nurse had been working there for decades, just as Dr Loza, and was an empowered figure within the ward. She had the authority, for example, to ask the occupational therapist and social worker for their report in the meeting. She also made proposals, suggestions, and expressed disagreement without constraint. Psychiatrists were not bothered by this, but they did voice their discrepancies whenever they disagreed with her. One of them openly complained in the meeting that some nurses ignore the agreements they make as a team and act as they please.

Complaints and disagreements, however, seemed to take place in a context of good relations. Dr Loza told me that one of the first prerogatives when he arrived in the early 1980s was to improve relations between the professions. According to him, they were now close, respectful, and collaborative. From what I observed, he had a close relationship with nurses. The chief nurse called him “old man”, for instance, and I saw him joke around with some of them. I also observed this tendency to establish a friendly bond in other relations, such as between Dr Loza and the social worker, or between the chief nurse and the residents.

In terms of their interaction with residents, the two main psychiatrists I observed established good relations with them and had the will to participate in their training. However, as I will recount, this was not the case with other practitioners at the men’s ward. On one occasion, I was having a chat with one of the residents outside the ward when she greeted a psychiatrist who was passing by, someone whom I always saw in the cafeteria drinking coffee. She said: “Evaluate him. They call him ‘god’ because he is always there but you can’t see him.” Although rates of psychiatric absenteeism have dropped, it used to be recurrent in the past. Residents found themselves in a ward without psychiatrists and were urged by the nursing team to do patient rounds. In theory, these rounds and their write-up lack validity if they are not supervised by a psychiatrist, who needs to put his stamp on the clinical record. However, although resident stamps are not a legitimate form of validation, they are accepted in the day-to-day proceedings of the wards.

I want to give way here to a wider discussion on the nature of educational relations in

psychiatry, in order to give some context to the resident-psychiatrist interactions I found in the field. Peruvian psychiatry has had its fair share of venerated historical figures that created distinctive academic and clinical traditions along the course of the discipline. Allegedly, one thing they all had in common was a vocation for teaching. In his book about a Peruvian psychiatric hospital, Stein (1995, p. 11) states that much of psychiatric training takes place in a personal and informal way through mentoring relationships where senior psychiatrists help younger ones in their training. I found a tendency to greatly appreciate teachers in some of the practitioners and residents I engaged with, who at some point referred to psychiatrists that had influenced them as “mi maestro” or “mi mentor”. It seems that the number of larger-than-life figures in Peruvian psychiatry has decreased over time, but to what extent is the inclination towards mentoring still alive in the present-day psychiatric hospitals?

There are two different kinds of teaching that have to be distinguished. The one that takes place while psychiatrists are delivering their service, which is unpaid and depends on their free determination to undertake it, and the external and more structured one that is paid and managed by universities. The latter includes the supervision of residents within the hospital, but also other activities such as giving classes at other academic institutions. This type of participation in psychiatric education is pervasive. Nearly all my informants had formal teaching jobs, some of them being involved in multiple endeavours and universities.

I found that the perceived quality of the two major psychiatric residency programmes, organised by two different universities, was dissimilar. While a junior doctor from Noguchi told me his residency programme had been of an excellent quality, residents from Hospital Valdizán complained about theirs. Pitfalls included poor practical supervision of residents and dissatisfaction with courses. As a consequence, residents tend to rely on themselves—“In this university we are autodidacts”—and on their relations with psychiatrists outside their residency programmes. For example, a practitioner from the outpatient area told me that, due to the poor support offered by university supervisors, she and other colleagues helped residents with their thesis without receiving any remuneration. Ward psychiatrists who voluntarily guide residents during their practice are another example I will discuss in the following lines.

The hospital organised a weekly event called Academic Tuesdays, which residents had to attend to discuss clinical cases. A resident had to stand up in front of his or her

peers, in the hospital classroom where the meeting was held, and describe a case from the wards, going through different items of the medical record. Then it was mostly the convener, a psychiatrist from the Department of Research and Training, who questioned the resident and tried to further elucidate the diagnosis. While in the past every department of the hospital participated in this event, present attendance of psychiatrists was scarce, with only two or three usually joining in. Second and third-year residents did not bother to attend either, leaving first-years by themselves with a small number of senior practitioners. Residents thought that the low attendance could be explained by the existing rivalry and power struggles between two groups of psychiatrists within the hospital. That is, given that the event was organised by the hospital's ruling group, practitioners from the opposition group refused to attend. The head of the Department of Research and Training, however, attributed low attendance to the fact that psychiatrists are not interested in clinical case presentations because it is not something new for them. They are attracted to novelty—articles and discussions about new topics and products, or a speaker giving a talk about current issues, for example. In other words, according to this interpretation, psychiatrists are not too interested in teaching.

Nonattendance seemed to be the main source of discontent among residents. While they were disappointed with Academic Tuesdays in general, there had been one successful session at the beginning of their training. Residents and psychiatrists from different hospital areas had been able to participate, generating an atmosphere of enriched exchange and discussion, which in turn led residents to feel enthusiastic about how much they were going to get out of these meetings.

Another issue I noticed was that the convener and the residents had a discordant set of expectations. In the presentations I witnessed, the convener made clear that he had higher expectations from residents. His interventions were almost exclusively corrections and questionings, and he repeatedly told them they needed more guidance. Residents, on the other hand, interpreted this approach as overly negative: "You feel bad. You prepare your presentation, your story, and the first thing they say is 'no, you're missing this, you're missing that, this is wrong.'" Whereas they expected these sessions to be about discussing cases, they were actually an evaluation of their capabilities to write up a case and present it. They juxtaposed them with the clinical case presentations held at the women's ward:

One of us presented the same story at the case discussion and at the ward. I even doubted the diagnosis when he presented it because they said: "You haven't asked this, you haven't asked that." It was as if the presentation was terrible. He did the same presentation the next day at the ward and it was alright and we reached an agreement.

They pointed out that criticism received at the ward was delivered in a more constructive manner, encouraging them to do better the next time.

The residents I became acquainted with were in their first year and, thus, in most need of guidance. They were satisfied with the two psychiatrists I followed in the wards: "We have enjoyed his patient rounds when he feels like it, because sometimes he just rushes through them. But he does make an effort to explain things. We are just getting to know him, but he shows great motivation in teaching us. He wants us to bring a book and do the rounds with it."

After the rounds, psychiatrists usually socialised with residents in the common rooms. These informal chats were often educational. Doctors talked about things they had read, past clinical experiences, or offered them career choice advice. For example, one practitioner told them about an internship he had done in the past at a clinical setting in Spain and recommended they look for these kinds of opportunities in foreign countries.

Dr Loza was the foremost example of these kinds of informal didactic interactions. The level of socialisation in his ward, as I have noted, was higher and this gave him the chance to reveal the whole extent of his psychiatric knowledge when discussing cases, clearing up others' doubts, telling stories or using examples to portray an argument. On one morning, for instance, they were in the meeting room discussing a patient who was a sexual assault victim and did not recognise her pregnancy. Loza told us about a textbook case, from a book he called "Goldman", in which a woman arrived at the emergency room without remembering her pregnancy. She had developed selective amnesia in order to forget she had cheated on her husband. Loza interpreted that the same was happening with their patient, whose amnesia was considered an emotional coping mechanism.

While at the women's ward the other psychiatrists also had the will to guide residents in their learning process, the situation was different at the men's ward. Residents said



about a psychiatrist of the men's ward: "He does his job, but never tells us to study a topic or discuss a case." Another practitioner was even more reluctant to engage with them, sometimes doing the rounds early in the morning before they arrived at the ward. He did not feel compelled to help them, as he had explicitly expressed: "I'm not your dad, I don't have to tell you what to do."

Residents, naturally, were fond of the psychiatrists who were willing to teach, and who they defined as being more empathic. One of them described the closeness they had established with these practitioners: "In other specialties it is much more vertical. In psychiatry, relations are more horizontal. In this hospital you can say we are friends with the doctors. We are friends over and above our academic relationship. This residency is nice."

As I have seen here, a great extent of psychiatric training in the hospitals is voluntary and depends on the goodwill of psychiatrists. The key institution in charge of managing residency programmes is not the hospital but the university, which arranges a series of courses and tutors that should guide and evaluate residents. The problem that arises from this institutional arrangement is that, given that practitioners hired by universities are not always present, training ends up having an irregular pattern and remains absent in some areas of the hospital.

If we look at the bigger picture, however, we find that psychiatrists who feel inclined to participate in the training of residents outnumber those who choose not to, at least in the two hospitals of my study. Some of them perceived the task as an ethical imperative. When I asked a Noguchi emergency psychiatrist about the training of residents in his area, he answered that it is mandated by the Hippocratic Oath. A psychiatrist from Valdizan's outpatient area, for her part, noted that she was committed to residents as a way of "paying it forward"; she had received the help of her seniors before so she felt compelled to do the same now.

Another motivation to engage in training that was brought up was more political in nature: to modify the fundamental orientations of residents in some way or another. The aforementioned emergency psychiatrist, for example, thought that residents had gone, in recent history, through a process of intellectual impoverishment. Thus, he was interested in "changing prejudices, motivating, and raising awareness" in order to instil a critical spirit in them. Furthermore, two other psychiatrists from the rehabilitation and community mental health areas welcomed residents with open arms "so that they

realise that there is another way of seeing the psychiatric problem and forms of treatment other than medicines," as one of them told me.

### Therapeutic Organisation

It was 11 o'clock in the morning when an elderly woman came into the consultation office at the outpatient area. "I see you look better," the psychiatrist told her right away, without imagining what was going to happen next. "I've come with my representative, she was assigned by the (Mormon) Church," the patient said, explaining the presence of the younger woman by her side. Without beating around the bush, the psychiatrist asked her if she still wanted to sleep. "Yes, it would be better," she replied. He went out of the office without saying a word. While he was away, the old lady told me about the doctors she had seen in the in the past, probably thinking I was a resident. The doctor returned 10 minutes later and handed the patient a piece of paper, telling her to sign it. She and the church representative did so without reading the paper, which made me think that she had been through this process before.

After arranging her hospitalisation, he conducted a brief interview:

Doctor: What thoughts do you have?

Patient: I want to disappear. I can't find a way out.

Doctor: How long ago have you had these thoughts?

Patient: For a month.

Doctor: How long ago did you stop taking your meds?

Patient: Fifteen days. I was abandoning myself. (She starts to cry.)

Doctor: You were fired from your job a month ago, right?

Patient: Yes.

Doctor: You don't have hope for the future...

Patient: No.

Doctor: Have you thought of a way of killing yourself?

Patient: Throwing myself from the fourth floor of my building. I tried to do it but was stopped by policemen.

At the end of the meeting, the psychiatrist handed over some medicines to the church representative and showed them out. I came across this patient some days later inside the women's hospitalisation ward.

This vignette represents one of two typical scenarios that fall under the category of psychiatric emergencies, the first one being a suicidal crisis. Psychiatrists are expected to evaluate the risk of committing suicide, taking into account if the patient has thought of how they want to do it, if they have tried to do it before, and their level of family support. The other situation that demands the hospitalisation of a patient is when they represent a threat to others. Patients will typically arrive at the emergency unit visibly agitated, sometimes screaming, in a state that is difficult to handle by their family. At this point, the psychiatrist evaluates the likelihood of the patient attacking someone, if this has not already happened.

In addition to these criteria, I found two other extra-clinical situations that affect the likelihood of psychiatric admission. The first one is the availability of beds in the emergency rooms and hospitalisation wards of the hospitals. As ER psychiatrists told me, sometimes hospitalisation is discouraged, or turned down, due to a shortage of beds in the wards. At other times, patients that could be evaluated longer and sent back home are rapidly hospitalised because the ER is overcrowded. This problem could be alleviated if more beds were assigned to the area.

The second scenario is when patients are at risk of being abandoned by their family members. At Hospital Valdizán, for instance, if the social worker encounters a dysfunctional family, she might tell the psychiatrist to think twice before hospitalising the patient. This behaviour is probably encouraged by the scarcity of places abandoned patients can be sent to after the hospitalisation period. The hospital cannot keep these patients in their premises forever and, thus, they find themselves in a real quandary when trying to place them in alternative institutions. As a consequence, there appears to be some degree of neglect on behalf of the hospitals, which results in a population of people with mental health problems living on the streets.

The following is a broad outline of the process patients go through in the emergency area of both hospitals. The psychiatrist first determines that the patient needs

assistance and medicates him or her according to their symptoms, after which the patient stays for observation for one to three days in the emergency area.<sup>22</sup> After observation, the psychiatrist has to assess if the patient has improved enough to continue treatment from home or if he or she has to be hospitalised. At Noguchi there is a hospitalisation board formed by three doctors (the attending psychiatrist, the chief of the emergency area, and the chief of the ward where the patient is going) who discuss the case, while at Hospital Valdizán the decision is only made by one practitioner.

Once inside the wards, at Hospital Valdizán, patients go through a progressive process of three stages called UCI (Unidad de Cuidados Intensivos), Intermedios and Generales. Each stage has separate rooms and activities. Psychiatry residents and doctors do complete morning grand rounds only with patients from the first two stages and then head to a meeting room where they sometimes interview patients that are in the final stages of their hospitalisation. In these interviews, they evaluate if the patient needs to stay more days in one of the stages or if they see enough improvement, or decline, for them to move forward or backwards in the therapeutic process. Residents and psychiatrists typically tell patients they are moving after interviewing them in the grand rounds. Most of the time this plays out as a natural, uncontroversial, decision. There were only two moments when I witnessed the staff debating these decisions.

Hospitalisations lasted, on average, between 30 and 45 days. On one occasion, I was watching a head of department make a presentation about the hospital to a crowd of medical students from the United States in the main auditorium, when he was asked how long hospitalisations last. He told them they lasted around four to six weeks and the students' class instructor replied, surprised, that he would love to have that much amount of time available, but in the United States insurance companies only cover hospitalisations up to 15 days. At Noguchi, on the other hand, there are two types of hospitalisation. Patients go through an initial 21 day phase (short-stay hospitalisation), at which point they can go home or stay in the hospital up to forty-five days (prolonged hospitalisation).

The goal of hospitalisation is the remission of target symptoms. In the words of a

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<sup>22</sup> However, at Hospital Valdizán, a new emergency area had been built and it became too risky to evaluate an agitated patient because the rooms were too small. As a consequence, psychiatrists started medicating patients and sending them directly to the wards, without going through the typical observation period.

ward psychiatrist, psychopharmaceuticals have their initial effects after two weeks, symptoms recede during the third week, and in the fourth they can conclude if the patient is stabilised or not. There are patients who do not respond to the medication and thus stay longer than others. The difference between the two hospitals, however, shows that at Noguchi the remission of symptoms is sufficient cause for discharge at 21 days, while at Hospital Valdizán they prefer to take an additional week to make sure symptoms will not recur.

Before discharging a patient they give them “permiso”, which consists of sending them home for a couple of days in order to confirm that they are in good shape and can be taken care of by their family. The decision of discharging the patient is made by the attending psychiatrist (each patient is assigned one), who has to call the family in. Patients cannot leave the hospital by themselves. If the family does not show up, then they are kept at the premises until they find an alternative housing institution. The discharge appointment with a family member is short. The psychiatrist warns them against changing or abandoning treatment, writes up the prescription and explains the medication regimen in detail. Then the patient is released into the outpatient care system, being referred to his psychiatrist within the same hospital or at another institution (not all establishments have hospitalisation services, so it is possible to find external patients in the wards). There are no special follow-up arrangements while the patient waits for his outpatient consultation, which usually takes three to four months. One ward psychiatrist at Noguchi expressed his concern over this excessive time lag and argued that the wards should make follow-up appointments ten to fifteen days after discharging a patient.

### Disciplining Patients

Compared to the long-term relationship that can be established by doctor and patient at outpatient consultations, in the wards this relationship is short-lived. After being discharged, patients do not see ward psychiatrists again. However, hospitalisation times allow for a certain degree of familiarity to be fashioned. In addition to this, some patients are hospitalised multiple times over the years and become better known by the staff.

Staff-patient relationships in the wards are more vertical and paternalistic than in

consultations, especially if we acknowledge the fact that many patients are hospitalised and treated without their consent. The wards are characterised by a disciplinary regimen in which the staff has a high degree of control over patients. This system is meant to prevent inmates from being harmed or impaired in any form, as well as to pave the way for their improvement. It was common for psychiatrists to show concern over situations that threatened to disturb the delicate therapeutic balance in which many of the patients are thought to be. For instance, the first time that I asked for permission to enter one of the wards, a psychiatrist told me he was concerned about how my presence would affect paranoid patients.<sup>23</sup>

Control over patients is tighter during the initial stages of their crises. The first moment, in the emergency area, is one of complete subjection: disturbed or agitated patients are put to sleep with injectables. They start taking their medications orally in the wards. The UCI area is a big room where patients are confined until stabilised. They remain in a state of relative segregation where they cannot see their families and are not included in undergraduate teaching rounds. They have to eat in their beds instead of joining the others in the dining room and, while other patients can use the pyjamas of their choice, they have to use the standard ones provided by the hospital.

While the other inpatients have more freedom than the ones in UCI, they are all subjected to a highly structured and authoritarian system. Daily routine is controlled by nurses who have to make sure patients eat and take medications at certain times of the day, as well as deciding what they watch on television or what bathroom they can use. I found some of their policies to be overprotective and impractical, like not letting patients talk about their problems between each other, hug themselves, or watch television programmes that show too much kissing. A language of discipline and paternalism also made its way, at times, into medical parlance, such as when a psychiatrist asked a nurse if a patient was “obeying orders”, or when another practitioner told a patient: “You’re going to Intermedios, you will behave yourself there.”

During rounds, patients were constantly reminded of how they should behave and this was tied to their possibilities of advancing to the next phase of their stay. For example, they had to do their chores, take their medicines, and not act out in any way.

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<sup>23</sup> Since I just observed grand rounds and did not interact directly with patients, my presence did not trigger any immediate or visible reaction. Patients acted as if I was not there. I did not further inquire if my presence had any less conspicuous reactions among patients, however.

On one occasion, we were next to the bed of a patient who I had seen progress from UCI to Intermedios. One of the first-year residents presented the case extensively. The patient had severe depression and post-traumatic stress disorder. She said she wanted to move on to Generales and a third-year resident, who was keeping us company, asked disapprovingly: "What's going to happen if we don't move you to Generales? Will you throw a tantrum?" The patient calmly replied, "No, why would I do that?" and the resident concluded: "I think you would."

A recurrent problematic behaviour that worried practitioners was escape attempts. The question "If you were allowed to, would you leave?" was part of one psychiatrist's repertoire, who also warned patients against trying to escape the ward. Another flagged behaviour was sleeping too much or at inadequate times. I watched doctors wake up patients they were about to interview in the rounds on several occasions.

Threats were commonly used as a means of making patients abstain from engaging in these forbidden behaviours. In a therapeutic team meeting, a psychiatrist told the chief nurse that her colleagues cannot threaten to send patients to UCI or tie them up to their beds. She acknowledged these practices and said she would talk with the other nurses. However, I found that another psychiatrist had similar habits during the rounds. After announcing that patients, those who were doing well, were going through to another area, he told them they would be sent back if they misbehaved. By reminding them of the possibility of stagnation or regression in the system of therapeutic stages, he was using their desire to leave the premises to keep them in line.

Patient response to this disciplinary regime varied. Some followed the rules, accepted what they were told in the rounds, and complied with taking their meds and any other activity prescribed by the therapeutic team. There was, nevertheless, a fair amount of dissent, from the polite to the defiant. Many patients asked to be moved to the next therapeutic stage, especially complaining about the ICU, which was regarded as unpleasant and boring. Others asked if they could leave the hospital altogether. Some, the most desperate, offered more dramatic displays of resistance, such as when a patient started crying because she wanted to get out of UCI and decided to openly defy the psychiatrist by telling her that she was going to throw out her pills.

There apparently was an increasing sense of empowerment among patients. In one therapeutic team meeting, a psychiatrist expressed his concern about this matter: "Patients are very demanding now." The chief nurse agreed with him: "You hear them

say 'I have my rights, you can't infringe them.'" I once heard a patient use this "rights" language. We were walking through Intermedios when a pregnant woman who had to go to a prenatal care check-up asked for permission to go by herself, instead of being sent in an ambulance. The practitioner replied that she did not have a doctor assigned to her and, hence, did not have anyone to ask permission to. The sign above the bed where her doctor's name should have been was, indeed, empty. "Don't I have the right to a doctor?" she challenged the clinician, who walked away and told the rest of the group to move on. There was another patient who used to belittle the female residents by calling them "enfermeritas", which means nurses in its diminutive form. This was a way of subverting the power that residents, as doctor figures, had over her.

There were specific patients, like the one who was pregnant, who had a bad reputation, a topic sometimes brought up during therapeutic group meetings. They were seen as a bad influence to others, making them behave worse, and some were perceived as manipulative. Collaboration between them was feared, as can be seen in the next dialogue:

Psychiatrist: You put all the "borders" (patients with borderline personality disorder) together.

Chief nurse: I have told them: "Why do you put them all together? They are going to form groups. Patient A associates too much with patient B.

Psychiatrist: Let's discharge her.

Disciplinary practices differed at the lower level of the division of labour within the ward. Psychiatrists and residents complained that nursing technicians treated patients too aggressively. A key issue they worried about was mechanical restraint. They acknowledged it as a necessary preventive measure for specific situations, such as when patients get dizzy after being subjected to electroconvulsive therapy and are tied to their chairs to prevent them from falling. However, they thought that nursing technicians used this measure indiscriminately. Mechanical restraint, they argued, can be untherapeutic because it generates distress, agitation, and paranoia, and it can bruise patients' arms if they try to forcibly break free. One of the residents went further and said it was a human rights matter. I saw this same resident express her disagreement with a psychiatrist once when we were in UCI and a patient was



restrained to his bed after falling to the ground.

Psychiatrists also intervened in some of these situations. There was a patient who usually got frightened when she was tied up after electroconvulsive therapy. On one occasion, her assigned doctor was concerned about this and told the nursing technician: "Untie her already." In the face of these problems, ward psychiatrists defined mechanical restriction as a medical decision. In one team meeting, a practitioner told the chief nurse: "Mechanical restriction is a medical act, you have to call the doctor. At night you can call the one who is on call."

On one patient round, we came across an older woman who was tied to a chair at Intermedios. She was surrounded by a couple of nursing technicians and seemed to be angry at them. It was strange to find mechanical restriction in the area where patients were supposedly doing better than in UCI. The psychiatrist asked if someone was bothering her and she answered: "The nurses. I want to get out of this chair. I'm tied up and without underwear, as if I weren't a person." She uttered these words, visibly distressed, with her eyes shut. Families also worried about this issue. It is seen as an aggressive practice that needs to be justified by hospital staff. This was another reason why nurses were advised to consult doctors before applying it, lest they suffer legal consequences.

Nursing technicians were generally more negatively regarded. They seemingly treat patients harshly, without patience, yelling and handling them in aggressive ways. "They think that you are not there, but sometimes you see how they yell at patients. And then, when they see you, they change their tone," one resident observed. "Certain words are used here: he is paranoid, he is delusive, he thinks everyone wants to attack him. But in the ER you are restrained by the neck or by the hands. And they will tell you he is paranoid, but maybe he is right to feel paranoid, he has just been restrained," another resident pondered.

One of the residents interpreted this ethical distinction in the practice of nursing technicians and other mental health professionals as due to a "lack of vocation". Others saw it as a lack of motivation that was tied to the temporal nature of their work. They spend much more time with patients, day after day, having to deal with the crying, the complaining, the fighting, and so on. This leaves them with a high level of job burnout. A resident compared this with the interspersed timing of her own job: "It's not the same to be there just for a little while, do the rounds, and pat them on the head." I would add an

additional analytic layer to the problem. It is possible that the marginal position of nursing technicians within the job structure of the ward contributes to their lack of motivation. The following account, by a ward psychiatrist, of a programme that sought to include them in the therapeutic endeavour resonates with this argument:

The addictions programme worked because we included the ward's personnel. We trained them, we worked with their fears. Many of them saw patients as sisters or aunts, cousins or daughters, who had this problem and preferred to remain distant. But they turned into the strongest part of the programme. We trained them in writing down practices and cognitive-behavioural therapy techniques, and the family therapist taught them to conduct group meetings. They felt rewarded for their work.

Nurses and psychiatrists do not generally treat patients in the rough ways that nursing technicians do. Dr Loza told me about how they made an effort to “humanise” patient care when he started working in the ward in 1983:

The first thing we did was humanise the ward. To be respectful with patients. We achieved this to a great extent. The most important measure, and which I think we lost for a while but we have been trying to rescue, was not to talk about psychotic patients, but about patients with a name and a last name.

In my observations, I came across expressions of respect, kindness, and attentiveness towards patients, but I also witnessed signs of impatience, bluntness and rejection. It was quite common for patients to make unsolicited requests to doctors, even when we were in the separate meeting room, and they were often mindlessly turned down.

I also had the chance to ask families if they were satisfied with the service provided during my 2007 fieldwork at Hospital Valdizán. A patient's sister expressed satisfaction with her brother's regular psychiatrist, who has been treating him since 2004. He showed real commitment, spending time with them and providing a good deal of information about the patient and his treatment. During his stay in the ward, her brother was assigned another doctor and the family complained about his lack of concern: “He does not call us, we have to look for him. And things should not be like this. He should tell us how his evaluation is going and what they are going to do with him.” As this family member's experience shows, and as I observed within the wards, attitude towards patients and families varies among practitioners. The difference between the

women's and men's wards is that the collective organisation of the first one seems to regulate staff behaviour to some extent.

## Psychiatric Interviewing and the Search for Awareness

Patient rounds at the wards are called "visitas" and consist, generally, of short personal interviews at the side of each patient's bed. They do this with every patient in UCI and Intermedios. Then they go to the meeting room and call in patients from Generales with whom they want to do follow-ups. The whole thing lasts between two and three hours. The first task is to establish the diagnosis. Patients generally come with a presumed diagnosis from the ER, or a confirmed diagnosis from the outpatient area, which has to be settled or modified in the wards. If a case remains in doubt, it can become a matter of discussion at the clinical case meetings that are held in the women's ward. This element of collective discussion is an advantage they have over other areas of the hospital where practitioners have to sort out dilemmas on their own.

The definition of a diagnosis, then, is sought by psychiatrists in the interviews that take place during the visita. Residents play a major role in the process. They interview families, elaborate case histories, and analyse the clinical picture in order to facilitate the emergence of a diagnosis. Although I did witness moments of diagnosis exploration in the visitas, the evaluation of patient evolution and adjustment of medication were the most common types.

The core group that gathered around each patient's bed was the psychiatrist, the three first-year residents that were rotating in the wards, and the head nurse, who always followed the group with her trolley. Additional people varied from time to time, including a third-year resident, a social worker, or interns. Noguchi's ward rounds seem to be richer in terms of attendance and interdisciplinary interaction, as the following account of a resident portrays:

You can see that the personnel are interested. They are all present in the rounds: the psychiatrist, residents, the psychologist, the social worker, the nurse, nursing technicians, and interns. And they give their point of view. They even debated about cases where they had different criteria, which is valid because it generates discussion and benefits the patient. It was good, I liked it.

In the Valdizán wards, discussion was confined to the psychiatrist-resident relationship. There were only sparse moments when the head nurse commented or was asked a question about specific aspects of the patient (“Has the patient slept well?” for example) that she, or other nurses, had observed in their daily work routines. For the residents, patient interviews were a great opportunity for learning. They watched psychiatrists conduct the interviews and then discussed the quandaries of each case with them on the spot, being able to ask questions if they had any doubts. At the women’s ward, residents also took turns to interview patients themselves, under supervision of the psychiatrist, while at the men’s ward the psychiatrist conducted the interviews and residents only wrote down on the medical record. One resident told me she learnt more when doing the interviews, while in the other ward she felt like she was losing her time and just being a scribe. The psychiatrists of the women’s ward took their idea of practical learning even further by assigning patients to each resident, thus making them further simulate the work practitioners do at the wards. It seemed to be the first time they did this, since the head nurse expressed her concern when she heard about it.

Interviewing was a big deal for the residents. One of them defined it as “an art” and they all looked up to the skills psychiatrists showed when performing interviews. All the ones I saw were short, ranging from five to fifteen minutes. Similarly to what I saw in outpatient consultations, they had a checklist style of questioning about symptoms and risk factors. However, these encounters were shorter due to the greater amount of patients that had to be seen. In what seemed like a moment of honesty, a resident expressed doubt about the effectiveness of this kind of interview: “I put myself in the shoes of the patient. If I am interviewed for five or fifteen minutes and if I am always asked the same things, well, I would probably lie.”

Moreover, open-ended questioning and prolonged patient narrations were harder to find. Interviews were predominantly directive, with psychiatrists sticking to their thematic grid at the expense of alternative topics brought up by patients. The use of close-ended questions was common, as in the following examples:

Do you feel sad? Angry? (The patient says he is worried.) Because you are here?  
Or because your family is going to visit?  
Do you think we can know your thoughts without talking to you? Does this  
happen on the street?

Has God given you a mission? Do you feel your body is heavy?  
Are bad people bothering you? Is it possible the devil has entered your body?

It feels like the psychiatrist is rushing to find the symptoms, probably because he or she cannot take too much time with each patient. Sometimes they obtained positive answers from patients and other times they did not. There were occasions when several consecutive questions failed to obtain findings, for instance. I want to argue that there are a set of possible negative methodological implications with this style of interviewing. On the one hand, the style is very direct. As the examples show, they straightforwardly ask questions about complex issues such as delusions the patient may have. This unsubtle style seems to ignore the methodological problems that may arise: patients can feel ashamed, confused, or annoyed by these questions and, hence, their answers could be questionable. On the other hand, it is possible that this insistent way of looking for symptoms will distort their real prevalence. Some patients may be induced into answering positively. These concerns become even more pressing in the case of individuals, like those diagnosed with schizophrenia, who may have cognitive difficulties such as disorganised discourse, disorientation, memory and concentration problems, etc.

In this part of the hospital, the most common ailment found is schizophrenia (at the outpatient area I found more cases of depression). By a wide margin, the most popular topics in the visitas were two of schizophrenia's positive symptoms: hallucinations and delusions. Psychiatrists asked directly about these, as if wanting to record their presence, and shortly learnt what they were about but did not get much further than that.

Two other themes that had an important presence in interviews, aside from psychotic symptomatology, were family relations and awareness of disease. Psychiatrists inquired about specific family relations or conflicts that may be a source of stress for the patient and may have played a role in his or her decompensation. This domain can also be evaluated by observing the reaction of patients to family visits. Emotions vary from eagerness to see them to anxiety and fear. There were cases when patients became estranged from their families, denying they knew them. In one of these cases, the psychiatrist construed this as part of the clinical picture of post-traumatic stress disorder.

Patterns of family visits also serve to evaluate the kind of support, or lack thereof, that patients have in their family environment. Family members may be unwilling or may have difficulties that preclude them from adequately taking care of the patient. Both of these scenarios can result in the patient being abandoned, temporarily or forever, in the hospital. I witnessed some cases in the wards in which families did not want to pick patients up after they had been discharged. Social workers are supposed to determine which families have economic difficulties so that the hospital can help them with expenditures and basic products during the hospitalisation period.

The other topic that emerged on several occasions, not only in the wards, was *conciencia de enfermedad*, which literally means awareness of disease. This element of psychiatric evaluation is known as “insight” in the English-speaking world and, although there is a vast literature that defines it as a complex and multifaceted construct, practitioners spoke about the term in a loose, self-evident manner. A distinction has been made between perceiving that something is wrong with you—a broader type of awareness—and attributing this negative state to a mental illness (Amador and Kronengold, 2004, p. 5). In the hospitals, however, I did not find the more general use of awareness, but a medicalised version of it. Patients are, or not, aware of having a disease in the medical sense of the term. They are aware, or not, of having a mental illness, such as schizophrenia, and needing psychiatric treatment. One psychiatrist even included specific knowledge about the disease into the category of *conciencia de enfermedad*, saying that patients could be aware, or not, of the chronic nature of schizophrenia.

Lack of *conciencia de enfermedad* is considered to be quite prevalent among persons with schizophrenia by the psychiatrists from my study. It is also seen as a predictor of poor prognosis. First, the practitioner has to check if the patient has *conciencia*. The following questions were used during ward visits: Why are you being treated? Why are you here? Do you have a mental illness? What disease do you have? If you could leave, would you do it? If the patient does not have awareness of disease and need for treatment, then he or she should be convinced by mental health professionals, a process related to the concepts of persuasion and psychoeducation that I developed in chapter five.

How the concept of awareness is used, then, and the purpose it serves in concrete hospital interactions, helps to consolidate a top-down psychiatric approach. The clinical

endeavour is centred around the psychiatric perspective: the patient has a mental illness called schizophrenia, he or she needs to be hospitalised and take antipsychotics, and this is a chronic disease in which the patient has to follow doctor's orders and be careful not to discontinue the medication. The patient's version of his or her malady only matters insofar as it shows its concordance with the psychiatric perspective. If it does not, it needs to be replaced by the dominant view.

### Invisible Patients and Scientific Authority

As I have reviewed, the style and content of psychiatric interviews within the wards reflect a medicalised form of practice that is centred around the empirical search of objectified symptomatology. This kind of approach was also portrayed by the residents' view of the psychiatric interview. When I asked them about their impressions of ward psychiatrists as teachers, they praised their ability to "find symptomatology that not many people can" and to "elicit information even from the most catatonic person", evoking a picture similar to that of detectives trying to determine the facts of a mystery case.<sup>24</sup>

This allegiance to the empirical model comes at the expense of the patient's perspective. An extreme example of the invisibilisation of the patient in the wards was when psychiatrists and residents acted as if the patient was not there. On one occasion, after finishing an interview, the psychiatrist voiced his opinion in front of the patient, "She is more stable," and a resident joined him in agreement, "She is more aligned." Then, the practitioner asked the nurse, "How has she been behaving?"

Sometimes patients protested about negative remarks made by psychiatrists in these exchanges. For example, once a resident paused an interview to tell the psychiatrist that the patient, diagnosed with schizophrenia, had threatened his mother with a knife. He told her angrily: "I did not do that. How can you say that? You are annoying just like my mother." The resident became visibly baffled by his reaction and did not know what to say. On another occasion, it was a psychiatrist who commented that he did not see any progress in a patient diagnosed with borderline personality disorder, to which she answered: "That's very mean for you to say, doctor." Unlike the

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<sup>24</sup> For more on the analogy between medicine and the work of detectives in medical education see Sinclair (2000).

resident, he maintained his composure and authoritative tone, telling her that it was the truth and that she had to get better.

As these instances show, there are moments when ward psychiatrists, in the midst of their symptom finding and checking, neglect their interaction with the patient. Another case in point showing the relegation of the patient's, and in this case also the family's, perspective is electroconvulsive therapy (ECT). This therapy is used to get rid of the symptoms of acute psychotic and depressive crises in the wards. It is provided as a last resort if symptoms do not recede with pills. However, a ward psychiatrist noted that it is also provided to patients who are known to recover slowly with medication.

Understandably, ECT generates concern in families. In 2007, I observed how the sisters of a patient diagnosed with schizophrenia wanted to oppose the application of ECT. They had vast experience taking care of him during his 28 years of illness and attributed a set of adverse effects to ECT (extreme sense of coldness, pain, dizziness, a staggering gait, and incontinence). Psychiatrists also echoed the negative connotations of ECT in their everyday parlance. When asked about ECT, a practitioner said that "it is still in use", giving a sense that it is an outdated tool. Furthermore, when reviewing who had been given ECT in the wards, another psychiatrist said: "this patient was spared".

However, nearly all the psychiatrists from my study were in favour of ECT. A young Noguchi practitioner I interviewed provided a good illustration of the psychiatric point of view on this issue. He told me that he used to be prejudiced against this practice, until he read the literature and saw the benefits of it on patients during his residency training. He argued that ECT should be looked at "rationally rather than emotionally" and "as one more tool for helping patients."

I was invited by a ward psychiatrist to witness a couple of ECT sessions. In the following lines I am going to describe what I saw in order to provide an account of the experience from a non-psychiatric viewpoint.

After interviewing a patient from UCI, Dr A pretended to place imaginary electrodes on his temples and asked if I wanted to see ECT sessions. Therefore, I followed him and the three residents to another hospitalisation ward. On our way there, the doctor had a friendly chat with the residents. They talked about the psychiatrists that had gone to the national psychiatry conference, which was taking place five hundred kilometres away from Lima. "That's why there are no pharma reps," one of the residents observed.



We entered the other ward through a back door and went into a small room called “Special Treatments” that had three beds in it. Dr A pinched the back of a nurse’s neck in a jocular manner as he arrived. A young woman was going to receive ECT. The psychiatrist observed while three nurses received the help of a resident in preparing the patient. The nurses said “alright”, followed by another “alright” from the doctor, and a resident pushed a button on the ECT machine, which seemed like a modern one. A resident and Dr A had a pleasant conversation, they laughed. The woman screamed while she was being given the shock. Dr A unplugged the machine after the round finished and wiped her sweating forehead while she was still lying down on the bed.

Another man who was in the room with us was taken out in a wheelchair with his head down and his hands tied by what seemed to be bed sheets. A resident checked a medical record with the doctor, who put a stamp on it and signed two separate sheets. There is an ECT record where the doctor has to sign every session undertaken.

Another patient walked in, she was young and looked relaxed. There was a great contrast between this image and how she ended up afterwards. She received an injection before starting ECT. The doctor said “alright” and I saw the woman’s feet shaking in the reflection of the bed’s metallic headboard.

The doctor signed the record and said, “I’ll see you in the ward”, before leaving.

Although there is a formal informed consent procedure that grants family members the power to allow this therapy to take place, I found some glitches in the process. The purpose of this system is to allow family members to make an educated decision by informing them about the treatment the patient is about to undergo. However, the hospital makes a family member sign this form when the patient is admitted to his or her hospitalisation and not when the decision really has to be made. Therefore, by taking this act of approval out of its context, rather than being a key moment in the treatment decision process, it is transformed into a secondary routine operation. In one of my 2007 cases, the father of a patient signed the consent form initially and ECT was applied without her mother knowing about it. If her father had recognised the significance of the consent form, he probably would have wanted to discuss the decision with the rest of the family. The mother felt anxious after finding out her daughter had been subjected to ECT. She thought it was an outdated treatment that kills neurons and that had debilitated the patient. I also met a family that was not asked for consent before applying ECT.

There was one occasion, also in 2007, when I participated in a meeting between a ward psychiatrist and the sister of a patient who had doubts about ECT being applied to his brother. She feared that ECT would make him dumb. When she mentioned this to the doctor, he haughtily replied that, although ECT may make you dumb in the short term, it is a proved fact that it does not have negative effects in the long run. He added that some patients receive the treatment between ten and twenty times a year and “nothing happens to them.”

Psychiatrists rest their support of ECT on scientific authority: the literature proves that nothing happens. Even though they are aware of the polemic status of this therapy and the disturbances that it produces on patients and families, they juxtapose their “rational” scientific stance with the “emotional” views of uneasiness, denying the latter’s legitimacy and imposing psychiatric considerations over the patient’s and family’s perspective.

There were also moments when patients asked about psychiatry’s concepts or methodologies, as in the following interaction between a patient and a psychiatrist in the ward’s meeting room:

Patient: He told me (his psychiatrist from the outpatient area) that I have psychosis, not schizophrenia.

Psychiatrist: Schizophrenia is a type of psychosis.

Patient: What is schizophrenia?

Psychiatrist: Why were you hospitalised?

Patient: Because I became obsessed with the devil, I undressed, I thought everyone wanted to harm me.

Psychiatrist: That’s it.

Patient: But... (makes a sign asking for a more concrete answer).

Psychiatrist: That’s it.

Patient: Alright doctor, I’m a schizophrenic, I’m going to take pills for life.

Here we see how a patient wants to understand the psychiatric concept that is being used to define him. The psychiatrist does not show interest in clarifying this information

too much and the patient, frustrated by this, mockingly accepts psychiatric discourse (“I’m a schizophrenic, I’m going to take pills for life”). And when patients, or families, appropriated psychiatric terms or offered an interpretation of events or a proposal, practitioners’ reactions were usually haughty, ranging from short answers to open derision. In another meeting room interview, when a patient said that she had panic attacks, the psychiatrist showed surprise and questioned her usage of this terminology (“What’s that? Who told you that?”) without informing her about its psychiatric meaning.

As I have seen, then, psychiatrists establish a knowledge hierarchy between them and the lay public based on the authority that science confers them and, at times, perpetuate the exclusion of patients and their families from psychiatry’s epistemic domain.

## Fragmented Care

“Ward psychiatrists are biologically oriented,” a young psychiatrist from the community mental health area had told me before I entered the hospitalisation wards. She had recently finished her residency there, so she knew what she was talking about. One of the residents rotating in the wards bolstered up the claim: “Everyone thinks about medicines all of the time.”

Psychopharmacology has a central place in ward life. In addition to how psychiatrists use pills, I witnessed the transmission of knowledge to residents. Residents have to learn the uses and side effects of each pill by observing practice or being taught directly. In the following example, a psychiatrist tells residents about the different possibilities for treating post-traumatic stress disorder during a therapeutic team meeting:

Sertraline is first-line treatment. Any other antidepressant can be second-line treatment. You can also give Mirtazapine for sleep. Sertraline has better long-term results. And anxiolytics are used when there is too much anxiety. Paroxetine is used for obsessive thoughts.

Furthermore, adherence to medication was a commonly expressed concern in the visitas. Psychiatrists checked if patients were taking their meds and if they thought they were necessary (conciencia). The risk of abandoning treatment was addressed with

varying strategies, the most benign of which was to inform patients and family members about their meds and to change medication when side effects were bothering them. Another form of ensuring compliance is coerced medication. This happens, for instance, when an agitated patient arrives at the hospital and is sedated with an injectable antipsychotic. Oral treatment is given to him only after he calms down and starts accepting the medications. But forced treatment can also take the form of covert medication. On one occasion, for example, when a nurse told the ward psychiatrist that a patient was not taking her pills, he decided to conceal the medication in her food.

Finally, there were also explicit threats of not letting the patient out of UCI if he or she did not take their medication, or they were shamed when treatment had been stopped. The following dialogue during an interview of a patient diagnosed with schizophrenia illustrates this:

Resident: You stopped taking your pill in March (six months before).

Patient: It made the back of my head hurt.

Psychiatrist: Did you tell your doctor?

Patient: No.

Psychiatrist: So whose fault is it that you have been admitted?

Patient: My fault.

Besides medication, the only other treatment found within the wards was occupational therapy. There used to be psychologists within the therapeutic team, but now they only come from the diagnostic department whenever they have to evaluate a patient. Some psychiatrists had psychotherapy training but did not apply it in the wards. There was only one time when I heard a reference to the practice of psychotherapy, when the head of one of the wards told another psychiatrist to apply stress management techniques with a patient who had been sexually assaulted. Patients in need of psychotherapy were, for the most part, referred to the departments of cognitive behavioural therapy and family therapy. In the words of one of the psychiatrists: "We refer patients that have a personality disorder, a depressive disorder, or some anxiety disorder to the Department of Cognitive-Behavioural Therapy."

The downside of this is that it takes a month for the Department of Cognitive-Behavioural Therapy to give an appointment. Thus, even though the patient has access to therapy, it is not always well coordinated with the patient's treatment itinerary. Psychiatrists were aware of this and remembered an addictions program that was implemented in one of the wards where cases were treated "integrally" rather than in a fragmented form. This program was coordinated by three different departments and fostered collaboration among family therapists, cognitive-behavioural therapists, and psychiatrists. The head of one of the wards noted that this collaborative work did not come without problems. According to him, psychiatrists had a tendency to underestimate their therapeutic counterparts, and nurses had a hard time trying to understand the different "languages" used by psychiatrists and therapists. He assessed it, nevertheless, as a programme that obtained good results. They subsequently tried to implement an eating disorders programme and a brief psychotic disorder treatment programme, but failed due to budget and personnel shortages.

Occupational therapy, the other kind of treatment within the wards, is composed of a diverse set of activities such as making newsboards, painting, watching movies, making handicrafts, doing exercise, etc. I found a critical discourse against this therapeutic sphere, mainly among residents but also more generally. Residents critiqued that therapists lacked motivation ("they call patients to watch a movie and they fall asleep and let patients sleep as well") and that activities lacked structure ("everyone does what they want"). But there is a more generalised perception among psychiatrists that patients in the wards waste their time doing handicrafts and other useless stuff. This perception comes coupled with a vague view that they should be doing more meaningful rehabilitative practices that will ultimately lead them to being included as productive members of society. But, as the head of the Rehabilitation Department told me, "nobody can be rehabilitated in forty-two days (hospitalisation period). What can be done is keep them busy, so that they can activate their mental and physical functions." In this way, the critique confuses different stages of the rehabilitation process and ignores the existence of the Rehabilitation Department's day programme that works with patients after they get out of hospitalisation.

### The Limits of Ward Treatment

There is no denying that ward treatment serves a useful purpose. A man whose psychotic crisis has been escalating during a week and starts putting his family's and his own life at risk is physically neutralised at the hospital, his symptoms wiped out, and slowly turned into a state where he can safely interact with his loved ones again.<sup>25</sup> However, as I will discuss here, this small victory comes with some problems and is threatened by the dangers of relapse that lurk in the foreseeable future.

The revolving door phenomenon is when patients who have been released from hospitalisation suffer subsequent relapses and are institutionalised over and over again. This applies to many ward patients at Peruvian mental hospitals. Rights advocacy institutions (Defensoría del Pueblo, 2009, p. 139; Mental Disability Rights International and Asociación Pro Derechos Humanos 2004, p.10) argue that the revolving door is caused by patients not being able to afford a regular course of psychotropic treatment. The illness course develops against a backdrop of social hardship where poverty, dysfunctional relationships and homelessness exacerbate negative outcomes.

The circuit of mental health and related institutions has indeed been historically precarious. Mental health services rely heavily on pharmacology. The presence of psychological treatment in the public health system is weak, to say the least. Social workers within the hospitals are scarce and in Hospital Valdizán they were regarded as sluggish and non-cooperative. The hospitals have rehabilitation departments, although as a domain of practice this remains marginal within the discipline. As I described in chapter four, Instituto Noguchi did an optimal job in creating community psychiatry programmes that offered follow-up and support to patients when they leave the hospital. Unfortunately, this tradition failed to extend beyond its original area of influence and has been increasingly neglected by the institution over time.

Thus, as the story of Carlos Rodríguez and his family shows (chapter one), living in poverty and in a precarious institutional context that provides little more than pharmacological treatment may result in an irregular pattern of psychopharmaceutical consumption and the chronification of mental illness, with patients having periodical relapses that make them return to the hospitalisation wards (revolving door).

In addition to high relapse rates, other problems of ward care were related to space

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<sup>25</sup> I do think that the conditions under which a patient is involuntarily committed can be improved, but that is a topic that exceeds the purview of my analysis.

and patient interaction. In the early stages of hospitalisation, at UCI and Intermedios, patients share open-spaced rooms with multiple other people, leaving no room for privacy. Many expressed their aversion to this situation. The number of beds in the rooms was also an aspect that psychiatrists worried about. While the hospital, due to demand pressures, wanted to add one more unit to UCI in the women's ward, psychiatrists wanted to take one out. Having too many beds meant that patients were uncomfortably close to each other, like at Intermedios in the men's ward, where four beds had almost no space between them.

Living in such close proximity has its dangers and can be untherapeutic. On the one hand, there is the physical risk of catching a transmittable malady. I learnt, for example, that head lice spread among patients in the wards. On the other hand, conflicts and violence are almost certain to occur. Patients complained that others had an unhygienic use of bathrooms or that they did not let them sleep at night. They annoyed each other and had petty quarrels and heated discussions. These sometimes end up in physical violence. Take, for instance, the case of two patients who got into a physical fight at the women's ward and were tied to their beds: "If you see her with that sort of behaviour, give her chlorpromazine because she can get disorganised and it's tough to reorganise her again. You have to be firm with her," a psychiatrist told the nurse while they were carrying out the rounds. What he meant is that fights cause the patient to develop cognitive impairments and, thus, negatively affects her therapeutic journey. One of the residents expressed her concern about how these episodes were handled: "There should be more privacy. There should be a separate room for agitated patients. They get agitated and everyone watches how they are tied down."

The men's ward also harbours sexual violence, mostly against psychiatric patients with intellectual disabilities. Residents at Hospital Valdizán suspected that one of them had been raped because he said that his bottom hurt. In order to prevent these attacks, patients with intellectual disability were sent home much faster than others by ward psychiatrists.

Thus, we can see how the way in which ward space is distributed works as a determinant of patient health. Living in open spaces with several other strangers and a small number of staff members affects patients' sense of comfort and their physical and mental integrity.

## Discussion

Therapeutic relations in the wards, as I have seen in this chapter, are quite hierarchical. In this setting, psychiatry manifests itself as a taken for granted, unquestioned, system of ideas and practices (Barrett, 1996, p. 10) that bears authority over patients and whose overriding goal is to make them accept its script and solutions. Psychiatry's power here is greater than in outpatient settings because patients are forced to comply if they want to be discharged. Thus, psychiatrists can afford to be more arrogant and ignore what patients have to say. They do not need to persuade, since they can impose.

The main psychiatric event in the wards is the bedside clinical interview carried out on a daily basis during "visitas" or patient rounds. I argue that these short and directive interviews narratively constrain patient discourse and psychiatric interpretations (Csordas et al., 2010). Practitioners seek to ascertain a number of predefined measures that are used to evaluate each inmate's evolution through close-ended questions. This evaluation is entirely based on the expert's interpretative grid, forced upon patients' own views and concerns. Determining *conciencia de enfermedad* (awareness of disease), a conspicuous element of clinical interviews in the wards, means checking if patients accept this interpretative grid. That is, if they accept having a specific mental illness and need to take medicines regularly in order to get better.

In addition to *conciencia de enfermedad*, psychiatrists also looked for symptoms and risk factors during visitas. Symptoms are treated as mere indexes of disease. Hallucinations and delusions, irrespective of their specific content, mean that patients are not getting better. There is no interest or analysis of psychotic discourse beyond this level of interpretation. Similarly, Van Dongen (2004, p. 219) observed how in a psychiatric hospital the subjective experience of psychosis is viewed as an obstacle to the therapeutic process, remaining excluded from the clinical relationship. Instead of explored, psychosis needs to be erased by medications. The same author argues that this is a form of symbolic violence that negates the possibility of meaning to alternative expressions of reality (Van Dongen, 2004, p. 223) that, in fact, can be informative about a person's predicaments and existential angst (229). Furthermore, Jenkins (2004, pp. 35-36) contends that psychiatry's focus on psychopathology ignores the "self-processes" by which people with schizophrenia struggle to remain oriented in the world.



Instead of treating them as passive victims of mental disorders, professionals should seek to boost patients' own "capacity for orientation in the world" (Jenkins, 2004, p. 39). In the wards, personal agency only emerged in negative form: some patients were accused of being manipulative and a bad influence to others.

In both the outpatient and hospitalisation areas of the hospital, there is certain discontinuity among psychiatry's ideas and practices that is presumably generated by the limited amount of funding and personnel. This context sets constraints that prevent practitioners from developing the kind of clinical practice they would like. Stein (1995, p. 49) defines this as "structural ambivalence": "While the personnel of such a hospital may articulate therapeutic goals, and may believe sincerely in these, there also exist structures which contradict what they articulate and believe." An example of this is the collaborative addictions programme that was implemented within the wards in the past. It was cancelled due to a lack of funding, but psychiatrists remembered it as a better form of treatment than what they have now. One of its virtues had been to motivate nursing technicians by giving them therapeutic functions such as making clinical notes and conducting group meetings. This, however, had also been lost and now psychiatrists perceived nursing technicians as aggressive and expressed their concern over their coercive behaviour and methods. Other authors have also documented how psychiatrists sometimes question the legitimacy of constraint practices in mental health care (Brodwin, 2014; Velpy and Eyraud, 2014; Hejtmanek, 2014).

## Conclusion

### The Empirical Model and the Inadequacies of Hospital Psychiatry

Psychiatric practice varies depending on the type of establishment in which it takes place. In private practice, for example, psychiatrists can see a widely varied assortment of mental illnesses, such as depressive, anxiety and eating disorders, just to name a few. In psychiatric departments within general hospitals, practice is more integrative: practitioners can treat mental states that are comorbid to medical conditions such as tuberculosis or HIV, and they can make endocrinological or neurological consultations with more ease. On the other hand, a large share of the mental hospital's illness configuration consists of major mental disorders, with psychosis being the most common among them. Psychiatrists from Hospital Larco Herrera, Lima's oldest psychiatric institution, are used to treating chronic patients with schizophrenia that have been abandoned by their families and live in the hospital, and also specialize in taking care of complex disorders such as neuroleptic malignant syndrome or dual diagnosis.

Hospital Valdizán and Instituto Noguchi are, in this sense, different from Larco Herrera. Psychiatric treatment in these hospitals is based on an acute model of mental illness, rather than a chronic one. Schizophrenia serves as a good illustration. Outpatient and ward treatment are focused on detecting positive symptomatology—hallucinations, delusions, and the like—and treating it with pills. The central purpose of hospital psychiatry is to “stabilise” these symptoms and prevent them from reoccurring. However, there is another set of symptoms in this illness that does not receive the attention it deserves from psychiatry. In many cases, the post-hospital experience of sufferers is pervaded by what are known as negative symptoms, such as a myriad of cognitive difficulties, apathy and lethargy. For the affected and their families, receiving care for this lingering aspect of the illness is as important as doing it for the acute crises.

In order to restore social and working relations, negative symptomatology is targeted by rehabilitation programmes that focus on cognitive impairments and the lack of social skills. The diagnostic labels that have been attributed in other areas of the hospital are not used by rehabilitation psychiatrists; they have a different evaluation system that focuses on specific disabilities and the patient's level of functioning. They even use a separate WHO manual called the International Classification of Functioning, Disability and Health (ICF). However, these departments, which do consider the importance of negative symptoms, have always held a marginal position within the hospitals, garnering little interest from psychiatrists and residents. Similarly to the depiction that Varma (2016) makes of psychiatric hospitals in India, the chronic ward at Hospital Valdizán remains almost unnoticed at the back of the institution. The work that can be done there does not fit the acute model of mental illness and is looked down upon as uninteresting.

Most public hospital psychiatrists thus work in outpatient and ward treatment settings. In the following section, I will give a final overview of hospital psychiatry as practiced in the outpatient area and hospitalization wards of Hospital Valdizán. I will assert that it is based on an empirical, pharmaceuticalized, and top-down paradigm; in addition, I will examine the inadequacies that make it an ineffective model of practice.

As I outlined in my literature review, the empirical model of psychiatry has its origin in the efforts made decades ago by the Neo-kraepelinians to create a biomedical-like classification of standardized psychiatric disorders, whereby practitioners could be more predictable in their diagnostic practices. It consists mainly in using a pre-determined checklist of symptoms—taken to be the core pathological structure of a disorder—to measure the course of the disease and determine what psychopharmaceuticals to prescribe or if dosages should be maintained or modified. There are also some environmental stressors, considered to be potentially dangerous, that are checked for during patient interviews, mostly related to family relations and personality traits. Furthermore, the empirical nature of psychiatry extends to the domain of psychotherapy, where cognitive behavioural therapy is the most valued form of practice due to its practical and straightforward strategies.

According to many senior practitioners, Peru's psychiatric academic centres adopted the empirical model as the official paradigm of training in the 1980s and 1990s, strongly influenced by the DSM and American psychiatric textbooks. In this way, they offer

technical education focused on the mechanics of diagnostics and pharmacology, without promoting the critical reflection necessary to compare different theories and forms of practice in psychiatry.

The empirical model is alive and well in the outpatient area and hospitalization wards of Hospital Valdizán, as I reviewed in chapters five and six. Outpatient consultations were of short duration, 13 to 20 minutes long, and their main thrust was the search of symptom patterns that led to diagnosis in new sessions and the assessment of these same symptoms in follow-up meetings. In this area, I found a variation between styles of questioning that were specific and directive—questions such as “Do you want to die?”, or “Are you constantly sad?”—and others that were more expectant and open-ended. In the wards, however, I found an oversimplified version of the empirical model, with psychiatrists interacting for five to fifteen minutes with patients in what felt like rushed interviews, perhaps due to time constraints. Practitioners only sought to check the presence of symptoms without exploring them too much, asking consecutive directive and loaded questions and getting only brief answers in return. Under these circumstances, it would not be surprising if some patients—many of which were in a distressed state or had cognitive problems—lied, or if their answers were influenced by the questions.

The other part of the empirical model is the prescription of psychopharmaceuticals. Although there was plenty of discussion about biologism dominating psychiatry among my informants, public hospital psychiatry is more pharmaceuticalized than biologized. Only one psychiatrist in my research cohort showed special interest in the biological basis of mental illness, and most espoused a biopsychosocial etiology model. Their reading habits are most likely centred on psychopharmacological treatment meta-analyses, and not on genetic or neurological psychiatric research. In any case, specific ideologies or interests did not make any difference in practice, as everyone prescribed in a similar fashion. “Med-checking” (Oldani, 2014)—evaluating the efficacy and side effects of pills—is an important part of clinical interviews and at the wards drug talk among practitioners and residents was prominent. The protagonism of psychopharmaceuticals is in part a product of the conditions of the workplace; many psychiatrists say that they also offer psychotherapy in private consultations, where they have more available time. Additionally, there are those who restrict their practice solely to diagnosing and prescribing in the public and private sectors, leaving counselling and

psychotherapies out of their repertoire.

Finally, allegiance to the empirical model can lead to silencing the voice of patients and families. As I have examined, there is a sort of scientific authoritarianism, the upholding of a firm epistemological hierarchy that posits psychiatric knowledge as unquestionable and disregards the patient's perspective. What patients have to say about ECT or psychopharmaceuticals, for example, is given secondary importance under the argument that "analysis (of treatments) should be rational rather than emotional", as one practitioner told me. Psychiatrists know, rationally, that these therapies are effective and, therefore, side effects and other complaints are the price to pay. Some of them are willing to ignore the patient and his or her family's will altogether by bypassing informed consent procedures or hiding pills in their food.

With regard to popular mental health beliefs and practices—such as the usage of idioms of distress, alternative healers, food supplements, herbal medicine and broths—that surfaced every now and then during consultations, the reactions from psychiatrists were varied. On the one hand, there were those who respected these ideas and choices, unless the service user was taking a product that could get interfere with pharmacological treatment. On the other hand, some did not react as well, such as a ward psychiatrist who laughed at a patient's mother when she asked if her psychotic daughter could take Bach flower remedies. Furthermore, three practitioners viewed the social and cultural gap between providers and patients as an obstacle to optimal communication. Instead of perceiving the problem as a product of their own lack of communicational abilities, they blamed it on patients. According to them, patients could not "express symptoms well", or had trouble understanding instructions, because they were uneducated (the words used were "pobreza de lenguaje", "bajo nivel cultural", "ignorantes", and "bajo nivel intelectual").

In outpatient consultations, psychiatrists were generally kind and empathetic with patients, with the exception of a practitioner who maintained a distanced and unsympathetic attitude. In the hospitalization wards, however, the story was quite different. Relationships there were rigid and paternalistic, with staff controlling daily routine to the minute and patients being treated like children: being threatened and reprimanded if they did not follow the rules and restrictions, and rewarded with progressing to the next therapeutic stage if they did. The coercive method of physical restraint was also used quite liberally. Naturally, the system had dissidents and they

were perceived by staff as manipulative and a bad influence to others.

Hospital psychiatrists have a basic tripartite strategic scheme to ensure treatment adherence (awareness of disease, coercion or persuasion, and treatment adherence). Awareness of disease means that the patient accepts the mental illness label and the need for treatment and it is seen as a prerequisite for attaining adherence. Thus, if a service user is not “aware”, he/she has to be coerced or persuaded, depending on the treatment setting. In the wards, adherence is achieved by coercion: patients are subjected to shaming when they stop taking their medications and they cannot progress to the next stages of the therapeutic system if they do not comply. These methods are not an option in the outpatient area so practitioners resort to psychoeducation, the process whereby they teach patients and families the psychiatric way of conceiving and managing mental illness. In any case, it constitutes a top-down approach that takes the patient as a passive figure who needs to embrace psychiatric treatment.

Psychoeducation, however, is not enough for promoting treatment adherence, as the high rates of treatment interruption among patients seem to imply (Jenkins and Kozelka, 2017). In most poverty-stricken places, such as Lima’s urban outskirts or Peru’s Southern Andes, economic and geographical access to medicines limit the capacity of people to adhere to psychiatric treatment plans continually. Another factor that can potentially affect adherence in a negative manner is the social gap between users and providers, and a therapeutic relationship lacking support and empathy. Therefore, if psychiatry wants to improve the likelihood of prolonged treatment adherence, it should inform about side effects, listen to patient concerns and offer support, monitor treatment on an ongoing basis, and provide complementary interventions that help the patient attain social recovery.

In his ethnography of psychopharmaceuticals in India, Ecks (2013) describes how some psychiatrists use a food metaphor, consonant with local culture and forms of care, in order to persuade patients to take psychotropic long-term treatment. He cautions that banalizing psychiatric pills in this way risks triggering inadequate use by patients, who are not aware of the dangers this carries. Although I did encounter this sort of practice that uses local cultural idioms in order to get the message through more effectively, I do think that handing out psychopharmaceuticals without informing about side effects and without carefully monitoring their intake is not taking these drugs seriously enough. It is

well known that inadequate use and drug withdrawal can have a deleterious effect on the course of the patient's illness.

Furthermore, I agree with Ecks (2013, pp. 12-13) that we should question psychopharmaceuticals even more than we already do. It is key to balance efforts of making them accessible with taking a critical stance and questioning their effectiveness and safety. To what extent, for instance, are the actual medication practices found in clinical settings based on sound evidence? Is it sensible for every person who has a first episode of psychosis to start taking antipsychotics? Is it sensible for service users to take antipsychotics indefinitely?

Moncrieff<sup>26</sup> (2013) expresses her concern about these issues and carries out a comprehensive review of the available evidence of the effectiveness and safety of antipsychotics. She states that antipsychotics are legitimately used at times when people are suffering from severe psychotic and manic symptoms that are deeply affecting their lives (Moncrieff, 2013, p. 217). After reviewing the evidence, however, she concludes that differences between antipsychotics and placebo in clinical trials are “not large enough to indicate that the drugs have clinically meaningful effects in real-life settings” (Moncrieff, 2013, p. 108). She also mentions evidence showing that, after a year, the rates of relapse in people taking the pills start to rise (Moncrieff, 2013, p. 103) and that, ultimately, people with the malady who do not take antipsychotics might have better outcomes than those who do (Moncrieff, 2013, p. 127). Furthermore, she refers to a considerable number of clinical trial design flaws that may have worked in favour of the psychotropics, such as the fact that studies using inactive placebos cannot really be considered to be double-blind (Moncrieff, 2013, p. 93), or taking withdrawal effects in placebo group participants who were previously on antipsychotics as signs of deterioration rather than a distortion of trial results (Moncrieff, 2013, pp. 93-94).

In terms of the harm that long-term treatment with antipsychotic can do— in addition to unwanted side effects such as tiredness, loss of motivation, impaired cognitive

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<sup>26</sup> This psychiatrist is one among other mental health professionals who have a critical view of the current state of psychiatric practice and the uses of psychopharmacology. Some years ago, for example, a large number of them subscribed an article in *The British Journal of Psychiatry* pointing to evidence that psychiatric drugs have limited impact over outcomes of mental illnesses, and that the main sources of improvement are factors such as promoting the therapeutic alliance, personal empowerment, and social inclusion (Bracken et al., 2012).

abilities, parkinsonian effects, among others—, Moncrieff (2013, p. 169) claims that the evidence is harder to deny:

There is substantial evidence that both the old and the new generation of antipsychotics cause irreversible neurological damage in the form of tardive dyskinesia, shrink the size of the brain, cause people to put on weight, disrupt the body's metabolic processes, heighten the risk of heart disease and stroke, and cause premature death, at least in some groups of people.

Given the high price that individuals frequently pay for the benefits of taking antipsychotics, and the fact that it is possible for some of them to recover from an episode of psychosis without ingesting these pills (Moncrieff, 2013, p. 129), the author concludes that they “should be used for the shortest possible period, if they cannot be avoided, and reduced gradually as soon as the individual shows signs of recovery” (Moncrieff, 2013, p. 131). This review and interpretation of the available evidence on antipsychotics is an example of how the effectiveness and safety profile of psychopharmaceuticals can be assessed and how this can lead us to questioning the practices and assumptions we encounter on the ground.

Finally, hospitalization wards at Hospital Valdizán have multiple questionable qualities that run counter to the goal of recovering from mental illness. The rigid disciplinary system of care and the cursory bedside interrogations reinforce the patients' passive role instead of promoting their personal empowerment. In addition to this, sharing rooms for more than a month with many strangers can be uncomfortable and dangerous. There are situations that occur in the presence of others that can affect the patients' sense of dignity, such as being intrusively questioned about your inner turmoil or being physically restrained to your bed. Other attributes and incidents such as the lack of space, the risk of catching infectious diseases, getting into fights, and being raped, all amount to a space that needs much transformation if psychiatry wants to provide a safe and supportive environment that fosters healthy relationships and promotes wellbeing.

The state of ward treatment is a consequence of lack of resources. These places are overcrowded with patients and the number of personnel is far from ideal. The problem of limited resources can be extrapolated to the whole mental health system, a result of the country's historical relegation of mental health policy. Even if the wards offered better treatment, it is just one discrete form of intervention in a system that lacks a diversified and coordinated system of care including strong psychological, rehabilitation,



and patient follow-up services. This leads to the revolving door situation, with patients relapsing periodically and developing a chronic course of illness.

The structural constraints of mental health services can serve to explain an apparent contradiction between what psychiatrists think and what they do in the hospitals. For example, most psychiatrists do not profess an unwavering allegiance to psychopharmaceuticals and some even display real caution in their use; however, their therapeutic centrality in the treatment system would make you think otherwise. This may be so because psychopharmaceuticals are easy to implement as a therapeutic action and hence tend to acquire prominence in low and middle income countries where mental health systems are underfunded. The same can be said about practitioners' warnings against a checklisting style of diagnosing if we compare them to the actual practices carried out in hospitalization wards.

Due to the neglect of the mental health sphere, there is a double standard of care in the public and private practices of psychiatrists and this is why some recommend private services to patients who can afford them. Some of the disparities are that private consultations are longer and can be held more often, psychotherapies and better pills are used, and practitioners form closer relationships with patients. The fact that salaries are critically low is probably a factor that precludes psychiatrists from becoming more involved in public hospitals.

## Mental Health Reform: diversification of interventions and research

After having assessed the state of public hospital psychiatry, I will now centre my attention on the mental health services reform efforts that were happening at Hospital Valdizán and Instituto Noguchi during the time of my fieldwork. I will analyse them critically and suggest how the national mental health reform agenda could be improved. Finally, I will discuss the role anthropology can play in the development of such an agenda.

I will start by discussing two topics that have been framed as problematic regarding global health policy: over-standardization and the dominance of quantitative thinking styles. Best practice models are promoted by the global health establishment and frequently taken up by countries that see them being legitimized through an

authoritative evidence-based rhetoric.<sup>27</sup> This streamlining process may overshadow components of diversity and innovation that are necessary for interventions to actually work in specific settings (Orr and Jain, 2015). Thus, it has been argued that global mental health has to pay more attention to all things local, including the experience of health professionals and patient populations, so that it can diversify intervention models and make them context-friendly.

In addition to this, interventions should be evaluated and the results published in a national database. This would help policymakers and healthcare professionals to engage in the processes of planning and innovation more efficiently, instead of mindlessly replicating the failures of past programmes in the way that Hospital Valdizán's La Reforma project did by undertaking a task-sharing model Noguchi had failed to implement years before. Furthermore, supporting the development of mental health research in the country, which is still quite weak today, would balance the unequal flow of knowledge that runs from international organizations and research centres to the projects being designed in Peru. It would also enable a middle-income country to enter the international circuit of evidence sharing, something necessary if we are to "realize a global mental health that is truly global in scope" (White, Jain and Giurgi-Oncu, 2014, p. 605).

The second issue, the hegemony of quantitative analysis in global health, is depicted by Noguchi's epidemiological studies project, which I consider to be a product of statistical fetishism.<sup>28</sup> The enterprise conducted by Noguchi's research director, Javier Saavedra, was one of vast proportions. Inspired by the mandate of mapping the prevalence of mental disorders in Peru, they had already conducted 70,000 interviews in several regions of the country by the time I met him. There was a political motivation behind these studies. They allowed psychiatric leaders to develop taglines, such as

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<sup>27</sup> In this respect, I was struck when I read Javier Mariátegui's 1987 book about his years as the director of Noguchi. In a chapter called "Towards a National Mental Health System", in which he discusses how such a system should look like, he does not make a single mention of international organizations. This marks a stark contrast with the writings of subsequent Noguchi directors and with present day articles on the topic, where such institutions and cooperation entities are always brought up as a concrete source of influence (most notably PAHO).

<sup>28</sup> Brotherton (2005, p. 341) defines statistical fetishism as "a heightened focus on ideological models and measures of health, in place of more nuanced accounts of the complex interrelationships among the individual practices of health care professionals and ordinary people, health policies, and state power."

“more than one third of Peru’s population has suffered from mental illness”, that could be pitched to politicians. Saavedra was clear about this: “You can persuade many people with numbers. We are doing this at the moment, persuading people from the regions, politicians, the whole country, that mental health is important, just by showing numbers.”

Although smart in terms of political strategy, the exaggerated prominence given to epidemiological studies has its problems. A first critique is that their emphasis on mental disorders obscures the social determinants that are linked to them, thereby posing psychiatry as the foremost solution and failing to make a multilevel epidemiological analysis that could better inform policy. Another critique is that they frame radically different cultural realities, such as the Peruvian Andes and Amazon, in an ethnocentric manner, using the usual labels of cosmopolitan psychiatry. Finally, these studies were very cumbersome and costly, requiring most of the human and financial resources available for research at Noguchi. This monopolization of resources diminished areas of research that were being pursued before—such as clinical studies—and precluded the possibility of developing new lines of inquiry such as qualitative projects.

A 2014 journal discussion between Saavedra and two epidemiologists that had written an article about Peru’s chapter in the WHO’s World Mental Health Survey (Fiestas and Piazza, 2014) lays the statistical fetishism bare. The epidemiologists mentioned the big gap in the prevalence figures of both studies: while Noguchi arrived at 37-39% for lifetime prevalence of mental disorders, the WHO study featured 29%. In the lifetime prevalence of depression, the WHO had 6.4% and Noguchi 16-21%. The epidemiologists explained this difference by criticizing Noguchi’s methodology and asserting that their results coincided with the ones from other countries in the region, which reassured them about the “validity and comparability” of their study (Fiestas and Piazza, 2014, p. 46). Saavedra (2014, p. 806) replied, on the same journal issue, by stating a number of methodological biases that the WHO study had and that could explain the different results.

First, this instance reveals how the representatives of the global health metrics-producing machinery (Adams, 2016a) try to assert their authority over a national actor, which had until then been the country’s bookkeeper of mental disorders, by making reference to their capacity of rendering different national realities comparable, thus

producing real global knowledge. Secondly, the regularly reified statistical figures became destabilized by this clash, their artificial nature revealed by measurements that differ dramatically. This, however, did not stop the “cascade of data” (Adams, 2016b, p. 30) from flowing in the following years in the form of more epidemiological studies (Saavedra et al., 2016a; Saavedra et al., 2016b). Third, if the real concern was to establish the high prevalence of mental disorders in Peru’s population, then this issue would not be of great importance given that the WHO numbers are still quite high. Furthermore, in the last decade, Peru’s Ministry of Health has been publishing studies that point to neuropsychiatric disorders as the most prominent group of causes of disease burden in the country, and consequently, they added them to the national basic healthcare insurance package in 2009. Therefore, the real concern in this debate seems to be who has the soundest methodology and, consequently, which numbers are correct. Adams (2016b, p. 33) warns that the desire to achieve fidelity of method and get good data in global health can be a distraction from the health problem being studied.

Research has to go beyond this overreliance on the statistical representation of mental illness prevalence. In order to yield a richer picture of the mental health landscape and fine-tune its interventions, the mental health reform agenda needs to scale up other forms of research focused on aspects such as the qualitative features of mental health and help-seeking, treatment outcomes, the provision of services, and policy-making.

## Treatment Paradigm Reform

In chapter four I described how one of the founders of Noguchi developed a community mental health programme with a psychiatric care paradigm that differed considerably from hospital psychiatry. This model of care had been sustained until the present within the same department. Examples of this are a psychiatrist who considers the cultivation of rapport with patients, recognizing their own views on their experiences, and creating a sense of community among them as critical cornerstones of mental healthcare. It includes nurses and social workers who look behind the curtain of symptomatology and help patients with their more pressing problems. It is a committed, patient-centred, psychiatry that dares to step out of its comfort zone and into the social realm providing

the context for mental illness. However, it had long been met with resistance within Noguchi's walls and, except for the examples cited, the purview of the initial programme has gradually diminished. I also found evidence that Hospital Valdizán's services reform programme had curtailed the psychiatric outreach services that were previously being delivered by the community mental health team.

The common stance among psychiatrists while I was on the field was to discard these community psychiatry approaches for being too limited in scope and posit services reform projects as best practice. The leaders who were promoting Hospital Valdizán's and Noguchi's services reform projects stressed the need to expand mental health services throughout the country and integrate them into the general health system, but said nothing about reforming psychiatric care. I do not think it is because they had not thought about it. Dr Quispe, for example, who was spearheading Noguchi's Proyecto Apurímac, had a different kind of praxis in his private consultations (he did not see patients in the public sphere) and felt that psychopharmaceuticals were overrated. But they probably did not see it as a useful path to take in their quest of convincing the profession and authorities about the need for mental health reform. Thus, I only found two psychiatric voices strongly advocating an alternative paradigm (community psychiatrist Dr Flores from Noguchi and psychoanalyst Dr Leguía from Hospital Valdizán) and they held a marginal position in the hospital setting.

So what happens with these reform projects when the dominant paradigm underlying mental health services remains unchallenged? Naturally, hospital psychiatry's empirical, cookbook approach is reproduced, only this time with the aggravating factor that its new contexts are health settings where professionals do not have any experience in mental health endeavours and have other main concerns. This is what I witnessed when I shadowed Dr Luis from Hospital Valdizán in his training sessions with primary care and hospital doctors. It was psychiatry in its most oversimplified expression, reduced to a simple diagnostic and psychopharmaceutical template that does not leave much room for interpretation, resembling the biomedical ideal of objectivity more than ever.

A very concrete concern here is the expenditure of psychopharmaceuticals. Dr Luis, for example, told a primary care physician that he should medicate patients with antidepressants for a year minimum if they have been sad for fifteen days and lost energy and motivation. At first glance, fifteen days seems to be a short amount of time to determine gravity of illness. Should a patient, who did not go to a primary care centre

or hospital asking for mental health help, be medicated if she or he has suffered a personal loss recently, for instance? In countries where mental health is integrated into the general health system, overprescription of psychopharmaceuticals in primary care has been identified as a problem and there are clinicians and researchers trying figure out how to amend this situation (Oldani, 2014; De Jong, 2014, p. 817). Misdiagnosis due to cultural miscommunication can also propel unnecessary prescribing that can lead to doing more harm than good (Good, 1992, p. 193).

Elizabeth, one of the psychologists from Hospital Valdizán's Department of Mental Health Promotion, told me that the general trend of the mental health service that they had set up in Huaycán was that patients went to see them three times and then stopped going. She did not know how to explain this because the programme they were implementing did not include researching this issue. The conclusion that I am attempting to arrive at here is that the ultimate goals of psychiatry and global mental health programmes should be to prevent treatment abandonment and to improve the long-term mental health of patients, including recovery as it is defined and desired by patients themselves. Those would be the real indicators of efficacy to aim for, which means reforming the model of the mental health system is not enough; the hegemonic treatment paradigm has to be reformed as well.

I have mentioned one kind of alternative practice that can be considered a reference for treatment paradigm reform: Noguchi's community mental health practice that has its origins in the 1970s and 1980s. Another type of alternative practice found in today's mental health system is psychotherapy. The demand for psychotherapy is such that even the most biologically-oriented psychiatrist of my research cohort wanted to learn its practice for his private practice (chapter three). In general terms, it is a well-regarded therapeutic tool and the new generations are more interested in its use than previous ones. However, cognitive behavioural therapy is privileged over other approaches because it shares biomedical psychiatry's empiricist epistemology and it is more practical. This represents a narrow approach that neglects the contributions of other perspectives such as psychodynamic or systemic therapies. Psychotherapies should be critically analysed, if possible ethnographically, in order to determine their contributions

and pitfalls in the healing of people with mental illness<sup>29</sup>.

Despite a favourable climate towards psychotherapies, approximately only half of psychiatrists practice them, mostly in private consultations. They are marginalized within educational curriculums—psychiatrists have to go out of their way to study them—and public practice; excess demand determines that consultations are too short for their inclusion. They had a presence in Hospital Valdizán, mostly under the jurisdiction of psychologists who offered cognitive behavioural therapy and family therapy. Furthermore, the presence of psychologists in non-psychiatric public health establishments is weak. In this sense, Noguchi's services reform project in Apurímac had the noteworthy aim of expanding the number of psychologists in primary care centres so that they could practice psychotherapy.

What is glaringly missing in the Peruvian psychiatric milieu is a model of care that addresses cultural diversity. At best, popular mental health culture remains unmentioned, as if it were not a concern of mental health services. At worst, it is seen as a handicap of patients—"myths and prejudices"—and a threat to psychiatric care. Peru is a highly culturally diverse country with three prominent cultural traditions—the Andean, Amazonian and European—and a coastal region, especially Lima, that is a melting pot of cultural influences. In a setting like this, psychiatry is in dire need of a service paradigm of cultural brokerage in which the differences between providers and clients are bridged by an adequate understanding and use of popular mental health culture and a fruitful collaboration with traditional healers<sup>30</sup> and other available local resources. As I reviewed in chapter one, anthropology is well-suited for providing this kind of expertise.

Another aspect largely absent from the Peruvian psychiatric establishment, and probably from many other low and middle-income settings, is a service user movement. Mental health advocacy organizations or support groups are basically made up of family members, who I was told were more interested in lobbying for involuntary commitment laws to pass in congress than in protecting patient rights. I heard this in the mental

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<sup>29</sup> Since psychotherapy is rare in public hospital psychiatric practice, it has not been a central focus in this study. I just made one attempt at gaining access to psychotherapeutic sessions but was turned down by a psychodynamic practitioner, as I discussed in chapter five.

<sup>30</sup> The inclusion of traditional healers in mental health interventions is not a central topic of my research, but I have mentioned some of the anthropological contributions and debates on the topic in chapter one. For further exploration of the relationship between Global Mental Health and alternative healing see Orr and Bindi (2017).

health reform advocacy group that I discussed in chapter two and I have not further explored the topic, but there was a clear negative sentiment towards family organizations in some members of this miscellaneous crowd. The point is that the creation of service user groups could help increase their potential to defend the patients' rights against threats from family members, psychiatry, or society in general. I did witness, as I have described in chapters five and six, some murky aspects regarding hospitalization decision processes, informed consent, and other aspects of patient care and treatment environment that should be improved.

Hall et al. review the multiple benefits that peer support in its many forms—from mutual support groups to peer mental health service providers—has on participants and on the institutions in which it takes place (2017, pp. 637-638). Given that people living with mental health conditions in low and middle-income countries lack power and that evidence of peer support interventions in these settings is scant (Hall et al, 2017, pp. 650-651), this should be a prioritized agenda. In the field, I found a small group of Noguchi patients, called ASUMEN, who got together because they wanted “to be heard” and eventually became supported by a human rights NGO. I went to their meetings a couple of times and they gave me, among other promotional material, a poster that I took home.

The sentences that appear on the poster are a good representation of the philosophy the group has developed: we have the right to participate and decide; we are persons, not just diagnosis; mental health: social health. In the view of a project coordinator from the human rights NGO, Noguchi staff and family members opposed their enterprise and reproduced the patients' state of dependency. ASUMEN, as its own members told me, sought the opposite: to break the ties of dependency, to make their own decisions and have an independent life where they can study, work, have friends, get married, and have kids. They also aimed to fight stigma and discrimination in their families and communities and to stop taking psychiatric medicines and achieve full recovery.



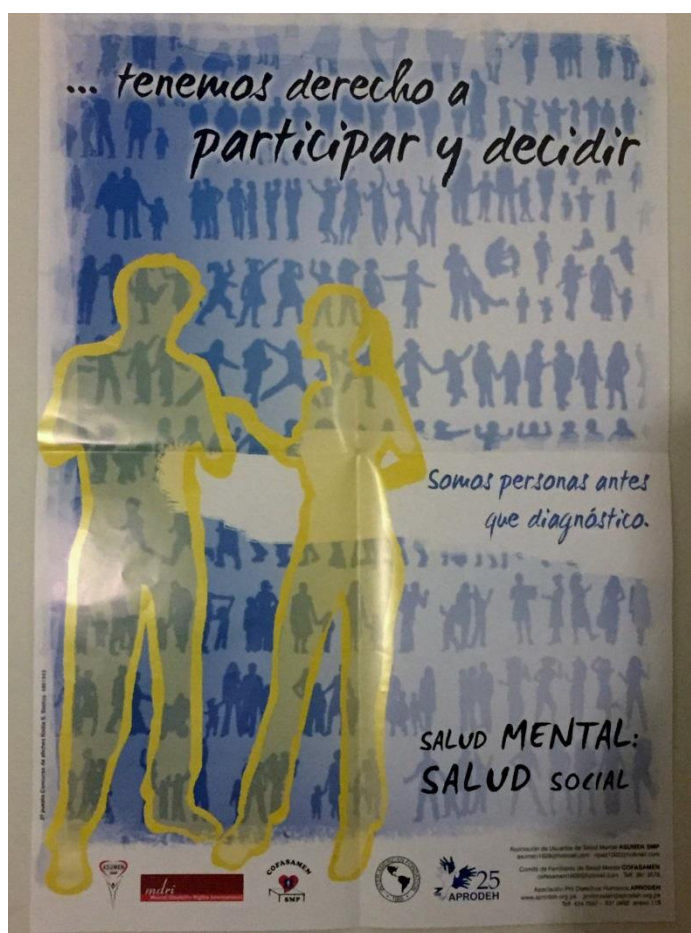


Figure 5. ASUMEN's poster.

### Towards Comprehensive and Locally-Sensitive Mental Health Services

In addition to treatment forms, another area of discussion is what sort of mental health system we are trying to achieve when undertaking a reform project. Until now, when Noguchi's Apurímac project is trying to include other elements, reform interventions have been centred primarily on task-sharing activities. Past Noguchi programmes, and Hospital Valdizán's current one, have focused their efforts almost exclusively on training health professionals of the public health system in how to detect and treat mental health issues. These programmes, however, have been unable to produce satisfactory results because of the complex nature of Peru's public health services. The obstacles are numerous: bad working conditions and high job mobility; a public sector audit style of governance (Shore and Wright, 2015; Owczarzak, Broaddus and Pinkerton, 2015) that

forces health personnel to attend to as many patients as they can in order to achieve performance goals, thus leaving no room for the introduction of mental health tasks; and hugely financed public health programmes, like the one devoted to tuberculosis, that divert human resources -even psychologists that are supposed to be performing mental health functions.

It is telling that the task-sharing projects applied by the hospitals of my research ended up with psychiatrists treating patients themselves, rather than just training the non-specialized personnel. This is the model that has sedimented in Noguchi's catchment area in Lima, where psychiatrists have their own consultation rooms in a small number of primary care centres. This failing of the primary care task-sharing model and a possible estrangement from the general healthcare establishment—which, as I showed in chapter 2, has historically marginalized the mental health agenda at policy and practice levels, and whose convoluted political dynamics have been a serious obstacle for the mental health field—has probably led Dr Quispe and his team to consider the use of specialized mental health personnel in primary care contexts, in addition to the training of other staff such as doctors or nurses. Project Apurímac, for instance, sought to include psychologists in primary care centres (chapter 4).

Furthermore, the development of specialized services reached another level after I finished my fieldwork and Dr Quispe assumed the direction of the Department of Mental Health at the Ministry of Health. In 2015, the Ministry announced the implementation of 22 Centros de Salud Mental Comunitarios (Community Mental Health Centres) with psychiatric, psychological, and occupational therapy services (Ministerio de Salud, 2015) in different regions of the country. By 2017 there were 31 of these centres already in place, and the Department of Mental Health declared that they want to build another 281 (Ministerio de Salud, 2017). 281 is roughly half the number of hospitals that Peru has all over the country (Lazo-Gonzales, Alcalde-Rabanal, and Espinosa-Henao, 2016, p. 56), so this goal is probably more realistic than having professional mental health personnel in primary care centres.

Having professionals in hospitals or separate mental health centres that treat complex cases, train and supervise non-specialists and non-professionals from primary care establishments is, of course, important (Patel, 2009). The challenge is, however, that the number of psychiatrists in regions of the country other than Lima is quite low. According to Defensoría del Pueblo (2009, p. 108), 81.82% (153) of psychiatrists

working for the Ministry of Health do so in Lima. Two regions have five psychiatrists, three have three, four have two, seven have one, and another seven have none (Defensoría del Pueblo, 2009, p. 110). This seemed to be a blind spot in mental health reform thinking, since I never heard or read any proposals about enhancing the specialized mental health workforce.

Creating mental health residency programmes in every region would require an amount of specialized trainers that is not presently available and who, probably, would not be willing to migrate to another part of the country for several years. Thus, task-sharing interventions with shorter training regimes remain a feasible option. These interventions, however, must go beyond the focus on training primary healthcare professionals in detecting and treating mental health problems. As I mentioned, this sort of endeavour has encountered many obstacles in the Peruvian context. In addition to training existent health workers, more staff and incentives to carry out mental health tasks should be incorporated in healthcare platforms.

Task-sharing should also go beyond training professional staff and engage with lay people (Kaiser and McLean, 2015), traditional healers, and peer providers that have recovered from mental illness (Myers, 2015a). This would make for a more contextually-sensitive approach (Patel et al., 2016, p. 8) that makes use of local resources and engages with popular mental health. Furthermore, it should include psychosocial interventions and rehabilitation and preventive activities. In this regard, while Noguchi's project Apurímac did contemplate training primary care personnel in all of these topics, Hospital Valdizán's La Reforma project only included counselling and treatment of disorders. It is worth mentioning that rehabilitation programmes should aim for what is more important to service users, which is social recovery. This should include aspects such as social relationships, job opportunities, stigma reduction, and socioeconomic support.

A possible avenue to explore in settings where specialized professionals are not available is telepsychiatry (Patel, 2016, p. 3080) or mHealth models (Burgess, 2016, p.736). Videoconferencing and mobile technologies can connect specialized staff with primary care settings in order to provide guidance or undertake patient consultations.

Resolving Psychiatry's Paradox: anthropology's social route and

## multidisciplinary collaboration

Finally, I want to reflect on the particularities of mental health governance in the country and how it can be improved. In relation to other disciplines, psychiatry has unquestioned hegemony in the hospital and policy realms. It is as if psychiatry and mental health were synonyms: the Instituto Nacional de Salud Mental (Noguchi) is a psychiatric institute and the national mental health direction at the Ministry of Health has always been led by psychiatrists. This position of great dominance is paradoxical because, as a profession, psychiatry has remained alienated from public health matters, absorbed in the daily practice of public hospitals and private practices. The paradox is aptly brought up in chapter three by a Hospital Valdizán community psychologist who expresses his frustration because, even though they do not want to do this kind of work, hospital norms establish that a psychiatrist has to be in charge of the outreach department. As a result, the chief of department was a young neurobiological psychiatrist who did not have any relevant experience for the job.

Exceptions notwithstanding, psychiatrists are fully dedicated—and that is where their interests lie—to clinical practice in consultation offices or hospitalization wards, both public and private. Noguchi practitioners, as part of a national institute, undertake more research practice than those at Hospital Valdizán, but it remains scant and overshadowed by clinical practice. The common motto regarding research among psychiatrists is “I would like to do it, but I can’t”. Low wages and the precarious working conditions of the public sector were brought up as factors that preclude them from doing research. If they were paid more, they would not see themselves forced to put up private practices and could spare more time in the public sphere for academic activities.

“Psychiatrists are too embedded in the specialty,” Hospital Valdizán’s director told me when I interviewed him in his office. The specialty has been firmly rooted in the medical model of clinical practice, remaining for the most part uninterested in the broader socioeconomic and political realities that affect mental illness and call for interventions that go beyond the walls of the hospital. Dr Quispe from Noguchi’s Division of Collective Health, for example, described how the Peruvian Psychiatric Association showed little interest in including the topic of services reform in its activities, whereas other professional groups of medicine, psychology and nursing were much more welcoming. The profession’s situation resonates with the state of affairs of global

psychiatry which, as Arthur Kleinman (2012, p. 421) suggests, “has painted itself into the narrowest corner, with limited relevance and an intellectual agenda that lacks excitement outside its small purview”.

According to many of my informants, the average public hospital psychiatrist is individualistic and competitive, mostly keeping to himself in clinical practice and thinking more about economic success than improving the system. The low turnout at the meetings of the hospitals’ “cuerpo medicos”<sup>31</sup>, where practitioners can come together and discuss any matter of concern, seemed to confirm these opinions. Moreover, hospital politics are characterized by antagonism and turf protection. At Hospital Valdizán, I found the institution was divided between two antagonistic psychiatric factions, one in control of the direction and the other of the “cuerpo medico”. Psychiatrists that did not form part of these groups saw the kind of politics that were in place as struggles for power that generated division and obstructed the progress of the hospital. Different factions could come together, however, if there was an external menace that the hospital needed protection from. Although this was true for the hospitals of my research, it was most conspicuous in the recent history of Hospital Larco Herrera. I met two senior psychiatrists from that hospital who both told me about the great reactionary forces that have opposed and frustrated past reform efforts within the institution in order to maintain their privileges in a context of unsupervised practice. The Ministry of Health surmounted the resistance in 2004 by imposing a reorganisation process with an external intervention committee that made immediate changes and by appointing a new director who would follow the committee’s recommendations.

Furthermore, given that they have been stationed within hospitals and that their position of authority grants them a great degree of independence, psychiatrists have not needed to mingle much with other professions and outside actors, thus remaining unaccustomed to the realities of teamwork and multidisciplinary and intersectoral engagements. The power clash between the PAHO and hospital psychiatrists which led to the latter leaving the advocacy group (chapter two) suggests that the powers that be need to learn a more flexible and collaborative style of leadership.

The kind of psychiatry described here is reproduced in education. The bulk of

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<sup>31</sup> These are internal organisations that represent psychiatrists at each institution and are supposed to protect the interests of the guild.

psychiatric residents of the country are trained in these hospitals, and residencies mainly revolve around hospitalization settings—even undergraduate medical students are only taken to the wards in their psychiatric rotations. In this way, residents become clinical psychiatrists and many of them stay in the same institutions after their training programmes end. In order to diversify the production of residents, other settings such as rehabilitation services, community mental health departments, and general hospitals should be given more importance in residencies. The trajectory of the Noguchi community mental health group illustrates how critical the training of residents is for the consolidation of a psychiatric field. Castro de la Mata did a great job creating a new psychiatric school but, after his death, his disciples did not continue the task of training the new generations and the relevance of the community mental health field gradually diminished over the years.

The case of Dr Quispe can be set as a contrasting example. He and Saavedra, Noguchi's research director, were the kind of practitioners I would call public health psychiatrists. Neither of them saw patients—at least not in the public sector—and devoted their time entirely to establishing a national research agenda and the health services reform project known as Project Apurímac. Quispe's performance since arriving to the Department of Community Mental Health—whose name changed to Collective Health when he got there—can be praised on two fronts. First, he managed to achieve the considerable support in financial and human resources that the division needed to implement Project Apurímac, thus reviving an otherwise marginalized area of the institute. Secondly, he changed the routine residents followed when they were in the division by getting them involved, not only in delivering services, but also in Project Apurímac activities, including planning and management meetings. As a result, two recent residents were working in the division at the time and others, although not working there, still collaborated with the project.

One of these ex-residents expressed the new sense of psychiatric identity that she had developed when I interviewed her:

We are committed to the job and we think that change in the new generations will come from Collective Health. For example, other areas such as hospitalisation give a discrete service related to the individual person. We have a populations approach, in the community, of greater scope. And we are closer to society. Public policy has to be centred on the person. You are going to see, if you go by,

that hospitalization services are very discrete. The doctor stabilizes the patient and he goes off. It's the same in the emergency room and in children services. This, on the other hand, demands great sacrifice.

This small innovation in psychiatric education made by Dr Quispe is evidence of how by creating new forms of training spaces psychiatry can generate more practitioners that are interested in public health matters and can contribute to a mental health reform agenda. This sort of strategy would help alleviate the paradox of psychiatry having too much power in the policy arena but lacking the human resources to meet the challenge.

The paradox, however, can also be alleviated by balancing out the power of psychiatry. Psychiatry and mental health are not synonyms; the latter is a field that far exceeds the former's reach and thus needs to include other disciplines. A significant inclusion of other disciplines would entail the democratization of decision-making within the mental health sphere, leading to a parity of statuses between psychiatry and other professions such as nursing, psychology, social work, or anthropology. Each discipline can contribute useful expertise in areas not mastered by the others, thus building an integrative field that could bring to life a real biopsychosocial model of mental health.

Anthropologists and other social scientists have skilfully documented how the social world affects the expression of mental illness, treatment decisions, and the rates and course of these maladies. It is vital to grasp this domain if we want to effectively improve the mental health of the population, but it is for the most part ignored in psychiatric practice, not just due to a lack of resources, but also because the profession lacks a social model of theory and practice. This deficiency is manifestly expressed by Bustamante (2009, p. 179) when he recounts the blind spots of the Ministry of Health's 2004 mental health policy guidelines: the absence of procedures to undertake democratization and community participation processes, the lack of tools for addressing the psychosocial consequences of the internal armed conflict in the affected population, and the absence of a gender and intercultural approach.

These are all domains in which anthropologists are competent. There is a new "social route", then, that the field of mental health must take, and in order to accomplish this, the inclusion of anthropology is indispensable. With an ample knowledge base of the social and cultural aspects of mental health and the discerning point of view that ethnography provides, anthropology can make myriad contributions to the field of public mental health. For instance, it can help enhance the reductionist research agenda that

over-relies on the statistical prevalence of a discrete number of psychiatric labels by incorporating local perceptions and practices and the social determinants of mental health into epidemiological accounts. Moreover, it can promote other forms of research that provide information on how to improve mental health services, preventive and promotional interventions, services reform programmes, and wider public policies that can tackle the structural determinants of mental illness.

Anthropology in Peru is as far away as it gets from making this contribution to public mental health. How, then, can the anthropological approach to mental health be bolstered and what chances does it have of attaining an empowered position in policy-making? In the past, there have been several instances where the social sciences have been used by psychiatrists or called on to collaborate in the mental health field. In the 1950s and 1960s, psychiatric figures such as Humberto Rotondo, Carlos Alberto Seguín, and Javier Mariátegui, while trying to develop a field they called “social psychiatry”, were reading sociological literature, working in multidisciplinary research teams and even presenting their work in social science academic events (Mariátegui, 1985, p. 258). Mariátegui would then become the first director of Noguchi, allowing it to develop a thriving community mental health department and a research area that engaged in qualitative research, which included sociologists. In 1990, the National Mental Health Plan proposed the inclusion of the social sciences in public policy and specific interventions (Ministerio de Salud and Instituto Nacional de Salud Mental, 1990, p.159). More recently, in the early 2000s, a Mental Health National Sanitary Strategy was created and its plan was drafted by a committee that included a medical anthropologist (Bustamante, 2009, p. 181).

While in the field, I came across an account that can serve as a cautionary tale about multidisciplinary collaboration. Two different people—a sociologist that had collaborated with Noguchi psychiatrists decades ago, and the community mental health veteran Dr Flores—told me that Castro de la Mata paired up with sociologists and social workers when he created his community mental health programme in the 1970s, but eventually kicked them out because they had a critical leftist discourse that accused psychiatrists of not having the necessary degree of commitment to the communities they served. This was clearly not a constructive model of collaboration. The aim of creating a democratic multidisciplinary mental health field requires the professions to lose any potential inclinations toward intolerance and divisiveness in favour of dialogue and



constructive argumentation. In a context like Peru where people who have the calling to work in mental health policy are scarce, it is especially important to form a firm alliance with professionals from other disciplines who are willing to work hand in hand with the social sciences, just like Castro de la Mata was.

I cannot say for sure what proportion of psychiatrists from the public sector is willing to give space to anthropologists in the hospitals or collaborate with them in mental health interventions and policies. From what I observed, and based on all the interactions I had, I would think that many of them do not have any problems, in principle, with anthropology chipping in. Many of them have a general interest in political and social topics and are aware of the influence that these domains have on mental illness. Many of them went a little further and showed especial enthusiasm regarding my presence and the possible contributions that anthropology could make to their practice. Only some have decided to take a different path in their careers and develop an alternative paradigm of psychiatric practice—such as the psychiatrists that were undertaking a community-based rehabilitation programme at Noguchi, which I have not described in this thesis—or try and influence policy through research and service reform projects—like the people in charge of the epidemiological studies and Project Apurímac at Noguchi.

Psychiatrists of this last group are anthropology's natural allies. They are the ones whose professional practice is the most akin to ours and who are willing to go down the path of reform in the mental health field. In the specific case of Noguchi's Collective Health Division, for instance, concurrently to Project Apurímac, they were departing from the standard clinical-epidemiological research that is generally done in psychiatry by developing a line of qualitative studies about topics such as mental health services, maternal suicide and bullying. In addition to this, the political influence that they were trying to have eventually paid off as Dr Quispe was named Director of the Mental Health Department at the Ministry of Health, which has given him the opportunity to start a national mental health reform process, an encouraging development that offers an opening for future anthropological input. This analysis allows me to think that the inclusion of anthropology in the mental health field is plausible. However, there is always the possibility that inflated egos, turf protection, and lack of teamwork skills get in the way, making the ultimate goal of balancing out psychiatry's ascendancy harder to reach.

Finally, it is important to look at ourselves and evaluate aspects that can be improved within anthropology in order to attain a constructive model of collaboration. In what terms should multidisciplinary collaboration be practiced? It is hard to imagine that meaningful work can be done if each discipline keeps to itself and merely shows their theories and research to the rest. It is likely, then, that there must be some level of interdisciplinarity (cross-fertilization) among the disciplines. Although this is something that many anthropologists have attained during their careers, it is a neglected approach at the level of anthropological education. Perhaps my own lack of engagement with psychiatric and mental health literature beyond the anthropological in this thesis is a product of my socialization in anthropology departments. In this sense, students can be encouraged to become more familiarized with fields such as psychology, social work, nursing, and neuroscience, which have a huge body of detailed work in mental health that can inform and enrich anthropology's views and critiques. This is not to say that students need to study each of these fields in detail; rather, they can develop an openness that can eventually lead to practical engagement in conversations, debates and collaborative work. For example, as Ecks and Kupfer (2015, p. 341) argue, psychiatrists may pick up information about the social aspects of mental illness in their daily practices with patients that anthropologists are not aware of, and thus it can be fruitful to hear what they have to say.

An obvious and significant problem today is that there are barely any Peruvian anthropologists studying mental health topics. Therefore, a critical task for researchers such as myself is to advertise the field in anthropology departments by organizing workshops, study groups, or courses that can guide students who already have an interest in mental health, or generate interest in those who are unfamiliar with the subject.



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